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 2

MAY 10–14 AND 17–19, 1965

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CONTENTS

PART 1

ADDITIONAL INFORMATION

PART 2

WITNESSES

COMMUNICATIONS

ADDITIONAL INFORMATION

SOCIAL SECURITY

MONDAY, MAY 10, 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, Douglas, Talmadge, Ribicoff, Williams, Bennett, and Curtis.

Also present: Senator McClellan of Arkansas.

Elizabeth B. Springer, chief clerk.

Senator ANDERSON. The committee will be in order.

Our first witness this morning is C. Manton Eddy representing the American Life Convention and other organizations. Mr. Eddy.

STATEMENT OF MANTON EDDY, AMERICAN LIFE CONVENTION, HEALTH INSURANCE ASSOCIATION OF AMERICA, AND LIFE INSURERS CONFERENCE

Mr. EDDY. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am very conscious of the strict time limit which has been forced upon the committee in these hearings. I have purposely condensed my statement to one that would not exceed 15 minutes, and with your permission, Mr. Chairman, though, I would like to ask the privilege, if it appeared desirable, to file at a later date within the proper time limits extended or supplementary testimony.

Senator ANDERSON. Without objection that will be done.

(The following was later received for the record:)

SUPPLEMENTAL STATEMENT RE SECTION 303 OF H.R. 6675

On May 10, 1965, Mr. Manton Eddy presented a statement on H.R. 6675 on behalf of the American Life Convention, the Health Insurance Association of America, the Life Insurance Association of America, and the Life Insurers Conference. That statement contained, on pages 6 and 7, a brief outline of the reasons for deletion of section 303 from H.R. 6675. It is the purpose of this supplemental statement to provide the committee with additional information showing the necessity for such deletion, information which was not contained in Mr. Eddy's statement by reason of the 15-minute time limitation thereon.

Protection against loss of income because of disability is the oldest type of coverage in the health insurance field. This coverage has been written by insurance companies for over 70 years and, at the end of 1963, almost 35 of 69 million wage earners had this protection. In addition, another 12 million workers were protected by other formal arrangements such as paid sick leave plans of Federal, State, and local governments, private industry and union plans, and plans of employee mutual benefit associations. There are also countless informal plans which provide for wage continuation. In 1964, over $1 billion

in loss of income benefits were paid to insureds by insurance companies. The amount of wage continuation benefits paid under the other formal and informal arrangements, noted above, is not included in this figure.

The first reason for deletion of section 303 was described as follows in Mr. Eddy's statement:

"Section 303 would change the concept of the disability program from one of early retirement for reasons of permanent and total disability to that of a temporary disability program. Under the amendment the Government would invade both the temporary and the long-term nonoccupational disability insurance fields. This would create broad-scale disruption, and either termination of private policies or serious overlap of benefits. There is no justification for further Government intrusion into the disability field since private insurance companies are providing broad coverage at reasonable premiums. The net result would be further to nationalize insurance in an area that is being responsibly and efficiently underwritten by insurance companies."

It should be recognized that the section 303 change in "definition," as it is characterized in the report of the Ways and Means Committee (p. 13), is not the type which merely clarifies the statutory description of a continuing concept. On the contrary, the section 303 redefinition of disability is actually a major change in the concept itself; i.e., from early retirement by reason of total and permanent disability to a temporary disability insurance program.

The proposal for such a change was not subjected to extensive study and hearings as was part A of H.R. 6675. Indeed, the hearings of the Senate Finance Committee provided the first opportunity for comment by the insurance business upon this long stride toward the total transformation of disability insurance from the private to the public sector. We believe it is fundamentally wrong to change a major portion of the Social Security Act in a substantial way on the basis of a hearing held on a totally unrelated proposal.

Perhaps it was this lack of opportunity for analysis and discussion which led to the misconceptions underlying House approval of section 303. For example:

1. The report of the Ways and Means Committee on H.R. 6675 states, on page 88, that when the Congress added disability benefits to the Social Security Act in 1956, it enacted "protection against loss of earnings resulting from extended total disability * * *." This is erroneous. Both the statute and its legislative history make it clear that the 1956 amendment provided benefits only if the disability would result in death or would be of long-continued and indefinite duration. The difference between "extended" and "indefinite" is the difference between "temporary" and "permanent."

The health insurance business appeared before your committee in 1956 when the Congress was considering the addition of cash disability benefits to the OASDI system. At that time it was frequently said by the proponents of such addition that even though the insurance business appeared to be making rapid strides in developing disability coverages, it did not seem that there was sufficient long-term disability coverage then available or written by insurance companies; therefore, Government should provide this type of benefit through the OASDI system. Those proponents clearly disavowed any intent or need for the Government to provide short-term disability benefits and contended that the Government should not go beyond establishing a disability program based on the concept of early retirement for reasons of permanent and total disability. The currently proposed section 303 is totally inconsistent with these basic principles thus enunciated in 1956. Furthermore, long term disability benefit policies are now widely available in a variety of plans designed to accommodate the public needs.

This entry of the Government into the temporary disability field would be critical for the insurance companies, both with respect to future business and with respect to existing business. The enactment of section 303 would seriously impair the issuance of such temporary disability coverage by private insurance companies and would make the Government the exclusive insurer for this type of risk. As for existing coverages, at least for those written on a noncancelable basis and those whose nonrenewal is limited by statute or company policy, the combination of section 303 and the benefits of the private policies would result in innumerable maximum claims, on both the Government and private insurance companies. Such combination would sharply increase the scope of overinsurance and its serious consequences.

It is occasionally heard that insurance companies should welcome the addition of short-term disability benefits to the OASDI system in that the companies could supplement or build upon the basic compulsory benefits. We submit that this is not true. The companies would have practically no margin under the

proposed amendments in which to supplement the governmental disability benefits. Based on the benefit schedule when the $6,600 wage base becomes effective in 1971, in the opinion of leading underwriters only those persons earning $8,000 or more per year could be insured if the governmental benefits and private benefits are not to result in overinsurance. This margin for the companies is practically nonexistent when the average annual income is considered.

The proposed amendments would, therefore, duplicate the coverages now written by insurance companies, would result in overinsurance enabling persons to receive more income while disabled than when gainfully employed, and would preempt the temporary disability insurance business to the exclusion of private companies.

2. The report of the Ways and Means Committee states further, on page 88, that "Your committee believes that the elimination of the requirement of indefinite duration from the definition of disability would help to meet the need for insurance protection of that substantially large group of disabled workers who, though totally disabled for an extended period, can be expected to eventually recover." This also is erroneous. The "need for insurance protection" has been and is being met by insurance companies making available a wide variety of such policies on both a group and individual basis, and for both long-term and short-term benefits. It should be specifically noted that this program is not designed for our aged population which, it has been alleged, cannot afford private health insurance coverage and, therefore, need assistance in fulfilling their medical care needs. This program deals with workers under age 65 and, so far as we know, it has never been alleged or demonstrated that workers as a group cannot afford to provide for their insurance needs. All evidence on this point appears to be directly contrary. In short, section 303 is concerned with income benefits of workers, rather than medical expenses of the aged.

3. The report states, on page 89, that the enactment of section 303 would simply "bring the social security disability program into line with the prevailing practice in private disability insurance." It is precisely for this reason that we contend that section 303 would put the Government into the temporary disability insurance business. Our national policy is not one of favoring Government programs which duplicate private programs. Rather, it is one of Government entry only into those areas where private enterprise cannot meet a public need.

4. The report further asserts, on page 89, that "The elimination of the indefinite duration requirement would also clarify for beneficiaries their rights under the disability program and at the same time simplify administration and help to speed up the payment of the first benefit check to disabled workers in those cases where a medical determination about the duration of disability is difficult to make." This, we believe, underscores a weakness, rather than a strength, in the proposed new program.

Having been in the business of writing disability coverage for over 70 years, we have learned that the status of the economy has a direct bearing on the number of persons claiming disability. We have found that persons with physical impairments who become unemployed find it is to their economic advantage to claim a disability when cash benefits are available rather than unemployment compensation. This distorts not only the incidence of disabilities, but also their duration.

The longer the term of benefit, the greater the overinsurance problem. Section 303 would create lifetime benefits, and the history of insurance shows such benefits lead to fiscal disaster. Disability insurance is written under a prime rule that to the greatest extent possible the economic incentive to remain disabled rather than to return to active employment should be avoided. This is done through establishing rather strict underwriting rules and time-tested methods of claim administration.

Under a total governmental program, claims administration would be extremely difficult due to the highly personal nature of claims administration for disability. The Government program would not have the benefit of the sound underwriting practices developed by the insurance business, which take into consideration all types of individuals and their circumstances. Pressures would most certainly develop to a point where the contemplated program could easily become a welfare plan and marginal groups of employees would be encouraged to retire from the labor market and receive cash benefits instead of returning to the labor force. This in turn could have a disastrous effect on the financing of the program.

The second reason for deletion of section 303 was described as follows in Mr. Eddy's statement:

"Section 303 would make benefit payments retroactive for the 6th month of disability. This would cause an overlap of benefit periods between social security disability benefits and temporary disability benefits written by private insurance companies, as well as State cash sickness programs."

The report of the Ways and Means Committee (p. 89) states: "Your committee is also recommending that entitlement to social security disability benefits begin at the end of the sixth month of continuous disability. Under the waiting period requirement in the present law, more than 7 months must pass after the onsent of disability before the disabled worker can receive his first benefit check. By changing the present requirement so that the first month of entitlement to benefits would be the last month of the waiting period, the first benefit check would be payable for the sixth full month of disability."

The foregoing excerpt from the report fails to justify the change for at least two reasons:

1. It does not recognize the fact that insurance companies have in force a substantial amount of disability coverage providing benefits for the first 6 months (26 weeks) of disability. The proposed change would make OASDI benefit payments retroactive for the sixth month, thereby creating a direct duplication of benefits for the sixth month.

2. The need for this portion of section 303 is alleged to arise from the 7- or 8-month period which results from the present 6-month waiting period. But the remedy for this lies not in the use of retroactive benefit payments, but in amendments of the Social Security Act and regulations thereunder so as to permit a month of disability to begin on any day of the month rather than disregarding partial months as is done now.

The third reason for deletion of section 303 was described as follows in Mr. Eddy's statement:

"Section 303 would create a duplication of payments under State workmen's compensation laws in all cases of total disability, temporary as well as permanent, lasting 6 months or more. It would thus result in many individuals qualifying for both State statutory benefits and social security disability benefits, a combination which would often provide more in tax-free income than the individual's take-home pay while working. The resulting adverse effect upon efforts to rehabilitate such persons, in our opinion, would be contrary to the best interests of both the public and the individual."

In 1949, the Ways and Means Committee wisely took the position that "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" and that "adequate safeguards should be maintained against unwarranted duplication of the two types of benefits. The total benefits payable under the two programs should not be excessive in relation to the purpose for which the benefit payments are intended." House Report 1300, 81st Congress, 1st session (1949), page 30.

The enactment of section 303 would violate the above criteria. It would remove the economic incentive for an injured worker to rehabilitate himself, it would add unnecessary costs to social security for job-connected injury and disease, and it would hamper efforts by the several States to improve their respective workmen's compensation programs.

As previously noted, it has been repeatedly demonstrated that disability tends to be unduly prolonged when overinsurance exists, particularly if such benefits are payable as a matter of contractual right. If these benefits approach the level of what might be earned in active employment—and it should be remembered that we are dealing with tax-free benefits—the incentive for returning to work is lost. Likewise, the incentive for a disabled person to become rehabilitated is a great deal less in many cases. The economic incentive to return to work or to seek rehabilitation, if necessary, depends upon the margin between earnings (after deducting income taxes, union dues, and other expenses of employment) over the tax-free and expense-free amount of disability benefits available.

It is also to be remembered that the persons with whom we are dealing in this area are not the aged, but persons of all ages under 65. These are the persons upon whom we depend for our productive capacity as a nation. Thus it is not only the welfare of individuals with which we are concerned, but also the welfare of the Nation. We believe that both are best served when disabled individuals are returned to a productive role whenever and as soon as possible.

The Ways and Means Committee has requested (p. 90 of its report of H.R. 6675) that the Social Security Administration conduct a study of the significance of overlapping benefits under the two programs. We think that this provides another reason for striking section 303 from the present bill. The study should be made first. Thereafter it can be determined what, if anything, should be done legislatively.

For these reasons, we urge deletion of section 303 from H.R. 6675.

Mr. EDDY. My name is Manton Eddy. I am senior vice president of the Connecticut General Life Insurance Co., Bloomfield, Conn., and currently president of the Health Insurance Association of America. I appear today on behalf of the American Life Convention, the Health Insurance Association of America, the Life Insurance Asociation of America, and the Life Insurers Conference. The 500 insurance companies in these organizations write over 90 percent of the health insurance issued by insurance companies in the United States.

As you know, health insurance is made available in the United States by insurance companies, by the various Blue Cross-Blue Shield organiaztions, and by other types of plans. In total, these plans provide protection for more than three-fourths of the entire population and over half of the population age 65 and over. Of these covered persons, the insurance companies provide hospital-surgical protection for more of both the general population and the aged population than all other forms of insuring or prepayment mechanisms combined.

The insurance business has always believed that citizens of all ages should have good medical care whenever it is needed. Such care should be available irrespective of the financial resources of the individual. Both private enterprise and Government assistance are, in our opinion, necessary to accomplish this objective. Private health insurers are providing a continually improving financing mechanism to meet the serious costs of medical care on a risk-sharing basis. We believe that the Government's role is properly one of assisting those who cannot pay their own health costs.

Over the years we have stated to committees of the Congress our opposition to the concepts embodied in part A of H.R. 6675. We continue to feel that such legislation is unnecessary in the light of the existing magnitude and growth of voluntary health insurance, coupled with governmental programs for those who do need help.

Last year, a bill passed the Senate providing basic hospital-related benefits. This bill failed of enactment. This year the President, in his health message, urged the Congress to enact a hospital insurance program for the aged to be financed under social security. The President stated:

Like our existing social security cash retirement benefits, this hospital insurance plan will be a basic protection plan. It should cover the heaviest cost elements in serious illnesses. In addition, we should encourage private insurance to provide supplementary protection.

This committee now has before it a House-passed bill going far beyond such basic protection. We welcome this opportunity to appear before this committee and to present for the first time to the Congress our views with respect to this bill.

H.R. 6675 is an unusually complex bill which combines major measures of widely differing kinds. Some of the proposals appear to be unobjectionable. However, we are especially concerned about new concepts put forward for the first time in certain sections of the bill.

With specific regard to part B, supplementary health insurance benefits for the aged, there are several reasons why we believe part B is an objectionable and unwise proposal.

1. In effect, it would require acceptance of a single supplementary plan instead of permitting a desirable flexibility and freedom of choice to people over age 65 to select from the many different kinds of plans insuring against medical care costs.

2. It would preempt so much of the field of insurance for persons over 65 that it is highly unlikely that any additional insurance, including insurance against catastrophic, high-cost illnesses, could be provided by insurance companies. The result is that persons over age 65 would have substantial expenses that they would have to bear directly and there would be pressures to enlarge the scope of the Government program with consequent higher costs and higher taxes.

3. Many persons over age 65 now have insurance that provides greater benefits than would be provided under part B. In some cases employers are paying all or part of the premiums. If part B becomes effective, it would be necessary to modify such insurance to avoid duplication of benefits. The result in many cases would be the discontinuance of this insurance.

4. A questionable concept would be introduced into the financing of the social insurance program by drawing funds from individual contributions and general revenues as well as from payroll taxes. True total costs would be obscured, fiscal responsibility would be weakened, and the possibilities for confusion and misunderstanding would be greatly increased.

5. Various other aspects of Part B are contrary to the principles that have been followed in our social security system. By making the coverage optional it is likely that those who need it least could most easily acquire it and benefit from the Government subsidy. Those who could least afford the additional contribution requirement would have the greatest difficulty in participating even though they would be the ones most in need of help. Instead of encouraging private initiative and effort, it would inject the Government into the insurance business. Not only would this be in direct competition with private insurance but the competition would be unfair because of the subsidy from general revenues involved in the Government-provided benefits.

6. Part A of H.R. 6675 is a modification of the King-Anderson bill, a proposal which has been subjected to intensive analysis and debate over a period of time. But part B has not been the subject of public hearing in the House of Representatives, and it has not until now had the benefit of public analysis and criticism.

Heretofore the OASDI program has dealt primarily with cash benefits. The provisions of the present bill relating to medical benefits are much more far reaching. Not only do they involve the expenditure of billions of dollars and substantial increases in taxes but they would influence in important ways how medical practice may develop, and the extent and nature of care that would be available.

A further serious concern arises because controls over medical practice could develop under a plan whereby Government undertakes to pay for medical services. The steps proposed, once taken, can never be retraced.

Part B calls for much more study and hence should be deleted from the present bill.

With regard to section 320, taxable wage base increase, under H.R. 6675 the taxable wage base would be raised from $4,800 to $5,600 on January 1, 1966, and would then increase to $6,600 on January 1, 1971, We oppose the projected 1971 increase to $6,600. It is our position that the wage base should not exceed the current average earnings of full-time workers covered under the system. This is because it serves not only as a tax base but also as a dividing line between the Government's responsibility in providing basic protection and the responsibility of the individual and his employer to provide for his security through the private sector. The 1971 increase to $6,600 violates this principle because it is only an estimate of a future average. There is no way to be certain that $6,600 will be the average annual wage in 1971.

The economic and other factors are too complex and too fluid to produce a reliable figure now. Increases in the wage base have never before been projected in the law. We believe this is sound policy and it should not be abandoned.

SECTION 303: DISABILITY INSURANCE BENEFITS

With regard to section 303, Disability Insurance Benefits, we have the following comments:

1. Section 303 would change the concept of the disability program from one of early retirement for reasons of permanent and total disability to that of a temporary disability program. Under the amendment the Government would invade both the temporary and the long-term nonoccupational disability insurance fields. This would create broad-scale disruption, and either termination of private policies or serious overlap of benefits. There is no justification for further governmental intrusion into the disability field since private insurance companies are providing broad coverage at reasonable premiums. The net result would be further to nationalize insurance in an area that is being responsibly and efficiently underwritten by insurance companies.

2. Section 302 would make benefit payments retroactive for the sixth month of disability. This would cause an overlap of benefit periods between social security disability benefits and temporary disability benefits written by private insurance companies, as well as State cash sickness programs.

3. Section 303 would create a duplication of payments under State workmen's compensation laws in all cases of total disability, temporary as well as permanent, lasting 6 months or more. It would thus result in many individuals qualifying for both State statutory benefits and social security disability benefits, a combination which would often provide more in tax-free income than the individual's take-home pay while working. The resulting adverse effect upon efforts to rehabilitate such persons, in our opinion, would be contrary to the best interests of both the public and the individual.

For these reasons, we urge the deletion of section 303.

Regarding amendments to the Internal Revenue Code, there is attached to my statement for the committee's consideration our recommendations concerning section 106(a) and section 106(c) of H.R. 6675. Important as we regard such recommendations, limits of time

prevent my reading them at this time, but they are a part of our statement.

Mr. Chairman, in conclusion, I sincerely want to thank the committee, both personally and on behalf of the organizations I am representing, for this opportunity to offer our views concerning this most important piece of legislation, H.R. 6675.

(The attachment referred to follows:)

AMENDMENTS TO THE INTERNAL REVENUE CODE

SECTION 106(a) OF H.R. 6675—SPECIAL DEDUCTION FOR ONE-HALF OF PREMIUMS FOR MEDICAL CARE INSURANCE

Section 106(a) of H.R. 6675 provides that section 213(a) of the Internal Revenue Code of 1954 shall be amended so as to provide the following deduction:

"(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."

This special deduction is available to all taxpayers who itemize their deductions. In addition, it is not subject to the 3-percent limitation on the deduction of other medical care expenses.

The report of the Committee on Ways and Means states that the purpose of this special deduction for medical insurance premiums is "to encourage the purchase of hospital insurance by all taxpayers." This is a clear recognition by the Ways and Means Committee and the House of Representatives as to the importance of private health insurance for all persons. We believe it is right and proper for the Congress to encourage all taxpayers to provide their own medical care protection by the granting of a special deduction for the premiums paid for medical insurance.

Unfortunately, after recognizing the need for providing a deduction for medical insurance, the House limited this medical insurance deduction to only 50 percent of the insurance premiums paid, but not to exceed $250. We can find no sound basis for restricting this deduction. Clearly, this restriction limits the amount of "encouragement" a taxpayer is provided. Private medical insurance is of sufficient importance to the economy and the whole country that it should receive complete "encouragement" and backing, not merely part or half encouragement. A full or 100-percent deduction is provided under the tax laws for such items as interest payments, taxes, and charitable contributions. Medical insurance payments are certainly as necessary and important as these items.

In brief, we can find no logical reason for placing restrictions on the medical insurance premiums deduction. We believe that a full and complete tax deduction should be allowed for these payments. Specifically, we recommend that section 213(a)(2) be amended by deleting both the one-half deduction limitation and the overall limitation of $250. This provision should be amended to read as follows:

"(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."

SECTION 106(c) OF H.R. 6675—INSURANCE CONTRACTS UNDER WHICH AMOUNTS ARE PAYABLE FOR OTHER THAN MEDICAL CARE

Section 106(c) of H.R. 6675 provides that section 213(e) of the Internal Revenue Code of 1954 shall be amended to read, in part, as follows:

"(2) In the case of an insurance contract under which amounts are payable for other than medical care referred to in subparagraph (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."

The purpose of new section 213(e)(2) is to specifically limit the deductible portion of premiums paid on multipurpose health and accident policies to the

actual cost of providing insurance protection against medical care expenses (as defined in new section 213(3)(1)).

A problem arises with respect to the requirement that the charge for medical care insurance must be "separately stated in the contract." There are many hundreds of thousands of existing contracts which do not contain a separate charge for medical care expenses. In order to comply with the requirement of section 213(e)(2), it will be necessary for insurance companies to amend these numerous existing policies. This type of amendment will usually require a change in the policy form which, in turn, requires the approval of the various State insurance departments. The processing of these policy changes can be both time consuming and costly to the insurance companies.

The obvious purpose of the requirement that the medical care expense charge be stated in the contract is to furnish the policyholder with the information as to the amount of his deductible item. This same information could be provided just as well in a statement furnished the policyholder by the company. In many instances, it would be more convenient and cheaper for the insurance company to furnish the information in a separate statement.

Accordingly, it is requested that section 213(e)(2) be amended to provide an alternative method of furnishing the medical care expense charge to the policyholder. This might be accomplished by amending section 213(e)(2) in the following manner:

"(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 *either* separately stated in the contract, *or furnished to the policyholder by the insurance company in a separate statement*,

"(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 (*or furnished to the policyholder by the insurance company in a separate statement*) as the charge for such insurance is unreasonably large in relation to the total charges under the contract." Italic supplied.

SECTION 106(C) OF H.R. 6675—DENIAL OF DEDUCTION FOR LOSS OF INCOME INSURANCE

H.R. 6675 should be amended to allow a deduction for the cost of insurance allocable to indemnity for loss of income. The social policy underlying the deduction for the cost of insurance allocable to medical care expenses applies with equal force in the case of cost of insurance allocable to income continuation payments, which not only provide protection (though in most cases only partial replacement of income) for the insured and his dependents during a period of disability, but enable the insured to meet those extraordinary expenses of illness which are not precisely characterized as medical expenses. Family providers should be encouraged to obtain this type of insurance.

Senator ANDERSON. Thank you, Mr. Eddy. This is a very interesting paper. You have done it in a good, short fashion which we all appreciate.

Under section 303, you speak of this change as undesirable, and it may be. But the present provision says "an event which can be expected to result in death." Isn't that a strict burden to put on a doctor to say that it is to result in death?

Mr. EDDY. I thought, Mr. Chairman, it was long and unpredictable.

Senator ANDERSON. I was coming to that, in terms of which can be expected to result in death or to be of long, continued, indefinite duration.

Would it help any—I am not trying to suggest this as your language—but would it help any if we confine it to a provision that would not permit anybody to receive more than 80 percent of what his aver-

age wage had been, to keep from having the double benefits which you are mentioning, and others have talked about?

Mr. EDDY. The prevention of double benefits is most important. But there is another point of principle, Senator Anderson, on which we are making our case, and that is hopefully not to have the Government intrude further into our insurance business.

The definition of "permanent" is a very strict one, but on the basis on which the legislation was first passed, I think the record shows that the intent of the Congress was to make provision as an extension of the old-age benefits program, an extension of a provision for those who were faced with, one might say, early retirement because of a future continuing disability. Originally, there was even the age of 50 as a limitation placed upon it.

We do feel that we in insurance have made available to the public a fine product at fair prices and that we are able to supply to public needs.

I am conscious of the fact that there are many cases where individuals do not qualify under the definition of permanent disability that result in strong letters of protest to Members of Congress.

But I would also submit to you, sir, that the disability field is one in which, whenever an individual is turned down, there is a protest.

We in private insurance find that in our claim processes, and I do not think it is possible to write a disability program that will not result in complaints. Perhaps, in shortening the term you might be encouraging, not intentionally encouraging, but end in finding that there would be more complaints than Congress is receiving now.

Senator ANDERSON. On your part B comments, you mention the fact that this puts the Government into the insurance business. I do not know how many people would take the plan, but apparently the House felt that a great many would. I do not know how many workers would, but supposing 50 million workers would take the plan, which is certainly a large number. At $72 a year, that would be a premium income, as I figure, of $3,600 million a year. How many existing American insurance companies have that much premium income?

Mr. EDDY. Trusting my memory, I would doubt that any have. But you rather frighten me, Senator Anderson. You have projected 50 million people. Either you are far in the future or you are dropping the age limit of 65, because I think we have only, as I understand it, 19 million eligible who are now 65 or over.

Senator ANDERSON. I realize that, but take 20 million, that is $1 billion a year income. There are very few companies which have that large an income; isn't that right?

Mr. EDDY. Very few companies have that; very few companies have that much income.

Senator ANDERSON. I think probably the Metropolitan and maybe the Prudential.

Mr. EDDY. My own company has approximately, in all forms of personal insurance, life and pension as well as health, we have approximately half a billion, and I believe on the basis of premium income we are considered to be in the first 10 in size. We do not consider ourselves a large company, but we are in that first 10.

Senator ANDERSON. Well, I am only trying to get you to say whether or not you feel it is a pretty substantial insurance undertaking for the Government to be in.

Mr. EDDY. Senator, I heartily agree with you, it is a serious and tremendous undertaking.

Senator ANDERSON. I say it only because I do feel it is going to take some hearings certainly on this one phase of it, and some very expert testimony by some, what I would regard as, very expert insurance people as to the problem of launching an insurance company with a $1 billion a year income, premium income, without a great deal of preliminary planning.

Do you regard that there is enough time in the bill for that sort of plan, or would you extend the period of it?

Mr. EDDY. I would certainly extend the period for hearings. I would trust that we are speaking of not enacting the legislation with a delayed effect. We are discussing a postponement of the legislation so that all the factors can be considered in these hearings.

Senator ANDERSON. The other day we had testimony by Blue Shield and Blue Cross, and the impression was left with me—I do not know about any others—that they might be a logical person to handle or insure this, and I thought at the time that it was a pretty fair-sized hunk of premium income to just hand a company without preliminary negotiation. I do not know how much the Secretary would negotiate, but there is a provision in here about a private plan. I do not know whether it would involve private companies in the ordinary sense or whether it was just to be done by Blue Shield, something of that nature.

As an insurance man, would you recommend a very searching inquiry into a question as to who would carry that load?

Mr. EDDY. I certainly would.

Senator ANDERSON. It strikes me that would be the thing to do. It looks like an awfully large company to start out afresh. I did not mean to get into a lot of questions of you, but it did strike me as a prety large program. Your company started with a small premium income; did it not?

Mr. EDDY. It certainly did. We are celebrating our 100th birthday this year. The premium we started with was hard to find in 1865. But I will say, Senator, when I joined the staff—it wasn't called staff in those days—when I became the so-called office boy in 1922, our total accumulated assets were $42 million, and we were quite proud of that at that time. But our premium income was only a few million dollars. And that was after——

Senator ANDERSON. $2 million?

Mr. EDDY. A few million. My memory isn't that good, but I know it was not too much, and that was after over 50 years of existence.

Senator ANDERSON. Senator Bennett.

Senator BENNETT. I have no questions. I want to join the chairman in thanking Mr. Eddy for bringing us this very well reasoned presentation of the problems from the point of view of the insurance agency, whose field is being invaded. I am glad it is a reasoned presentation rather than an emotional one.

Mr. EDDY. Thank you.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. Mr. Eddy, while part A puts the Government into the insurance business, it is an extension of the OASDI into a more or less new field, is that right?

Mr. EDDY. Yes, sir.

Senator CURTIS. Part B clearly starts a new Government insurance program, does it not?

Mr. EDDY. Yes, sir.

Senator CURTIS. And according to the way you read the bill, who will run this insurance?

Mr. EDDY. Well, I really do not know, sir. There might be some speculation, but I would think in the last analysis it is going to be HEW.

Senator CURTIS. I would think so, plus the Congress. It will be a political insurance company, and we start right out with the Federal Government paying half of the premium for everybody, for every enrollee regardless of his financial circumstances, isn't that correct?

Mr. EDDY. Yes, sir.

Senator CURTIS. I do not want to take too much time on that, but it will have a considerable impact upon private insurance relating to people over 65, will it not?

Mr. EDDY. I might even call it a devastating impact.

Senator CURTIS. Yes.

Mr. EDDY. It practically moves us out of the over-65 market with respect to any of our private insurance companies.

Senator CURTIS. We have heard a great deal of talk in this country about the Government competition with private enterprise. Well here, with one stroke, the vast Government insurance ventures undertaken at a premium rate that is probably drawn out of the air, I don't know where they got it, and the Government is going to subsidize half of everybody's premium.

Mr. EDDY. Yes, sir.

Senator CURTIS. And you think that the individual who wants to turn to private enterprise to purchase his insurance if he is past 65, if this is enacted, and once it gets in motion for a while, his opportunities to buy are going to be very much reduced, is that right?

Mr. EDDY. Very much reduced. After all, sir, if one can buy a product at 50 cents on the dollar, he usually does.

Senator CURTIS. Well now, without asking you for too much detail, just what progress has been made by private insurance companies in improving hospital and medical insurance for people over 65? What progress has been made in the last 2 years?

Mr. EDDY. If I may refer to a note I have——

Senator CURTIS. Surely.

Mr. EDDY. Actually, sir, it is testimony from an insurance witness last August before this committee. May I read it because it says better than I could ad lib it:

> We have estimated that 60 percent of the noninstitutionalized aged population were covered by some form of voluntary health insurance at the end of 1962.

Then another sentence:

> These studies, when related to earlier studies, reveal that the number of people aged 65 and over with health insurance protection has about tripled during the decade 1952 to 1962.

That, sir, is the number of people if we speak of a portion of the aged population.

> The proportion of the older population covered has doubled during the same period.

Senator CURTIS. Has that been because of added efforts on the part of the insurance companies to meet this need that has come to the forefront?

Mr. EDDY. Very definitely so. The insurance business has felt a challenge and a responsibility. It is a field that is admittedly difficult to do good work in, but the private companies have expanded their offerings, State 65 programs have come into being, and all in all I think the net result has been to provide an attractive line of products for people with the ability to pay. We must say with the ability to pay. There is no possibility for private insurance to provide benefits to people without the ability to pay because we would have to draw on resources of others, and that is not possible within our business.

Senator CURTIS. And in line with that, it is also impossible for either the Government or the private insurance industry to determine what the costs of medical care are going to be; isn't that right?

Mr. EDDY. I think it is very difficult; one of the greatest problems, sir, is that the costs are not static costs. We all know that the costs of health care, particularly of hospital care, have shown an annual increase. I believe the record is 7 percent per year over the past decade. Many actuaries in protecting the immediate future, provide for a 5-percent per year increase. Chairman Mills, of the Ways and Means Committee, I think, was very careful in putting in the proviso that the $6 cost, shared equally by Government and individual, would be reevaluated every 2 years, so that it would be certain that the Government would not be paying more than half the costs.

With any sensible projection into the future, it is obvious that $3 will not stay in being for very long. The Congress will have to legislate or it will have to be determined that a higher dollar figure will have to be used.

Senator CURTIS. In reference to hospital costs, Senator Saltonstall read into our record here the other day a study made in New York under some group under the direction of the Governor that indicated the time may be fast approaching when the cost of a hospital bed would be $100 a day, in that area.

But what I am trying to point out is: that is a different problem than who provides the protection for it, isn't it?

Mr. EDDY. Yes, sir.

Senator CURTIS. Now this bill would indicate, it is not too clear in many respects, that outside carriers or Blue Cross, Blue Shield, or someone, would be contracted with to administer it. That is particularly true of part B; is it not?

Mr. EDDY. Yes, sir.

Senator CURTIS. Has private insurance had any experience in that?

Mr. EDDY. One of our companies, the Aetna Life, is the lead company for insuring the indemnity program under the Federal employees health benefits and has, I think, perhaps a quarter of that coverage. That is on an insurance risk-sharing basis——

Senator CURTIS. Yes.

Mr. EDDY. But, on the basis of being an administrative operation, not sharing risk, but merely being a pipeline through which the Government money flows out to the beneficiaries, the military medicare program is a case in point.

Senator CURTIS. You are speaking now of the families of servicemen?

Mr. EDDY. Yes; families, dependents, of servicemen, and that is divided, I believe, between the Blue Cross Association and a very fine company, the Mutual of Omaha which, I think, is one of the fine representative companies of your good State, sir.

Senator CURTIS. How long has that gone on? It has been several years, hasn't it?

Mr. EDDY. It has been several years. I think it is longer than 5 years.

Senator CURTIS. In general, what are they called on to do? They just administer benefits. They do not collect any premiums.

Mr. EDDY. They do not collect premiums. They administer benefits, and it is a very close parallel to what presumably an insurance company or a carrier would be expected to do under part B.

Senator CURTIS. They administer benefits and process claims.

Mr. EDDY. That is right, sir.

Senator CURTIS. And then pay benefits.

Mr. EDDY. That is right, sir.

Senator CURTIS. And then are reimbursed.

Mr. EDDY. They are reimbursed by the Department of Defense.

Senator CURTIS. What has been the experience of private insurance in this field of servicemen's families?

Mr. EDDY. I think——

Senator CURTIS. From the standpoint of costs to the system and efficiency, and so on, and how does it compare with the Blue Cross, Blue Shield part of the operation?

Mr. EDDY. Well, perhaps I could best answer your question by saying that the 1964 report of the dependents' medical care program showed that the administrative costs per claim of the two hospital contractors were $2.31 by the Blue Cross Association, and $1.26 by Mutual of Omaha.

Senator CURTIS. Did they both have a sufficient portion of it that it would be a fair comparison?

Mr. EDDY. Well, as I recall, the Mutual of Omaha's share is about, is only, 13 States, perhaps a third of the total, so I would answer, "Yes," to your question.

Senator CURTIS. As an insurance man do you have any reason as to why one costs less than the other?

Mr. EDDY. Well, I have always felt, sir, that the profitmaking system has a greater challenge to perform than the nonprofit system.

Senator CURTIS. Will you give those figures again, a dollar what?

Mr. EDDY. $1.26 per claim administrative costs by Mutual of Omaha, and $2.31 per claim by the Blue Cross Association. That is in the 1964 report of the dependents' medical care program.

Senator CURTIS. And while there is an assignment which is limited geographically, so far as you know, they were both administering the same benefit program?

Mr. EDDY. It is identical, the benefits are identical. It is just a different geographical area.

Senator CURTIS. Yes. Has service outside of the continental United States been a factor in making a difference in the costs?

Mr. EDDY. I am not aware of that, sir.

Senator CURTIS. Well, one other question. I am intereseted in your comments on the amendments to the Internal Revenue Code, and that will have to have some further attention, but may I ask you this: Are

those technical in nature or do you advocate some basic change in the tax structure?

Mr. EDDY. Perhaps one is technical and two might be considered philosophical. The technical one relates to the provision that premiums for medical care are deductible, provided that they are separately stated in the insurance contract. Because of our difficulty in amending contracts and the requirement of going through State supervisory officials for approval, which is a gargantuan task, we would like to see the language permit the statement of separate premiums to be, in what one might call a separate statement of fact rather than in the contract itself.

Another one, which I say may be philosophical, is that it is proposed that there be a special deduction for one-half of premiums for medical care insurance. We feel that the principle is right or wrong—and we feel it is right, and we say it should be all.

The last is a recommendation that the tax deduction for premiums, medical premiums, be extended to cover those for loss of income because so frequently the insurance premiums paid for loss of income are really important during a period of illness, and while they do not go directly toward the payment of a hospital or a medical bill, they could well be a major part in supplying the reimbursement of such expenses.

Senator CURTIS. There was a witness here the other day who pointed out that by raising the wage base to $6,600, and lowering the rate, what the House bill really was doing was lowering the social security tax at a time—for more than one-half of the workers—when substantial benefit increases were being voted. Your comment does not go into that problem.

Mr. EDDY. No, it does not go into that. Again, my comments, our comment, is more a philosophical one. We do not say that the wage base should not increase. It has increased in the past. We have not, I think, as a matter of principle, opposed it in a point of time.

We do think it is wrong in principle for the Congress to legislate in advance of what a future wage base will be.

Senator CURTIS. That is all the time I will take, Mr. Chairman.

Senator ANDERSON. You made some remarks about health insurance for the aged people. We have some figures, and I wish you would check them with your group, and if you find something different, we would like to have it. Ours show over 8 million aged have no health insurance at all, about half the aged with commercial insurance policies covering hospital care, have policies providing less than $10 a day for room costs, and very little coverage for other purposes; only about 1 in 20 have health insurance protection that covers about 40 percent of medical costs in their lifetime.

I am not as interested as the Senator from Nebraska about this question of the invasion by the Government into this new insurance company. I will worry about that when the time comes, but I am worried about its actuarial soundness, and one of the things I missed in the testimony of the Department of Health, Education and Welfare was some reason to show why there was the $6 a month premium. Do you have any information on that on the basis of what the hazards are which are covered? If so, I would like to have you submit

them because I do not think there is any testimony before us which shows the reasonableness or unreasonableness of $3 a month from the person, and $3 a month from the Government as a contribution toward this insurance.

If you had a million people who were policyholders or policy purchasers, rather, they ought to know something about the justice of the charge or the injustice of the charge. We got into disability insurance and we were getting along fine with the disability after 50, and then somebody came along and said to wipe it all out because we were not having any claims, and then the fund went into the red which, I think, is very bad for any insurance company, and I hope you will agree with it.

Mr. EDDY. It is not only bad, it is disastrous.

Senator ANDERSON. I think it can be. It has not acquired that situation as yet, but part of this increase in the wage base, I think, is for a portion, a partial coverage of some of these charges.

What I would appreciate from you or any other insurance firm is a study of what this $6 a month means against a million policyholders, and the hazards that are covered by it. As you and I know there is the temptation every 2 years to change the social security law a little bit—and someone might say why doesn't the whole $6 come from the Federal Government instead of the $3; if it is insufficient you would have to start charging again.

I would like to know the soundness of the program. I personally do not think we have very much data as to how it would be administered, because—Senator Curtis got the same impression I did—this might be turned over to Blue Cross or Blue Shield or some other organization, and that might not be the best place to put it, I do not know.

Mr. EDDY. Senator, I would like to think that I know a lot of answers, but you have asked such a wide range of questions, would I be permitted to secure from the reporter what you have just said and then to file with this committee the evidence we have and the studies we can provide to give you our views on those costs?

Mr. ANDERSON. Mr. Eddy, that is why I asked the question, not for this morning but if you would do it sometime later——

Mr. EDDY. Yes, sir.

Senator ANDERSON. Because one time I was working on a bill called the King-Anderson bill, I submitted the material in it to a very large life insurance company, and they took some time and made a study and pointed out a great many things to me that I had not considered at all, and those things were changed in subsequent versions of the bill.

Now, I feel it might be possible to find something in the House bill just possibly that might be wrong, and we ought to at least be able to look at it, and I would like to look at it. Anything you can file of that nature would be very much appreciated, and I extend the invitation to any other insurance group or firm, including Mutual of Omaha, which seems to have made a very good record in the administration of this Government program.

Mr. EDDY. Thank you, sir, I shall do my best to see that your query is extended widely throughout the insurance world.

(The information referred to follows:)

CONNECTICUT GENERAL LIFE INSURANCE CO.,
Hartford, Conn., May 17, 1965.

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: During my appearance before the Senate Finance Committee on May 10, 1965, Senator Anderson asked me to provide information as to the actuarial soundness of the program called for by part B of H.R. 6675. As I indicated at the time, estimates of costs under such programs will vary depending upon the underlying assumptions upon which they are based.

As shown in the attached memorandum, under the assumptions believed appropriate by actuaries of the insurance associations which I represent, the initial cost of the benefits of part B are estimated to be $7 per person per month. It is expected that these costs will increase appreciably in future years and we believe will reach $18 per person per month by the 25th year of the program.

My comments were also requested with respect to certain statistics on health insurance coverage of people over 65. These comments follow.

The statistic of "over 8 million aged" with no health insurance is derived from a study conducted by the Social Security Administration. It was based upon a household interview survey of a sample of the population over age 65 and refers to coverage as of the end of 1962. While the results of such surveys contain much that is of interest, they are subject to a degree of variation due to sampling, respondent error, and the memory factor. That the latter can be significant among the aged may be observed from the results of a somewhat similar survey conducted by another agency of HEW. The National Center for Health Statistics has found, for example, as much as 17 percent underreporting of hospitalization episodes by the aged interviewed in such surveys. If almost one out of every five aged persons did not remember such a traumatic experience as a hospital episode, it is likely that they would have similar difficulty with respect to reporting the ownership of a health insurance policy. This would be particularly true where the policy, as is often the case, is purchased by a son or daughter.

It is of additional interest to note that the "over 8 million" uninsured aged in 1962 included, according to the SSA survey, the institutionalized aged (some three-quarters of a million) as well as the noninstitutionalized. The 8 million also includes about 2⅛ million aged receiving old-age assistance (and as such are eligible for medical care under the vendor payments progam) as well as an unknown but substantial number eligible for assistance under the MAA program. The latest survey of the Health Insurance Association of America, based on actual records from insurance companies and other insurers, indicates that 10.6 million persons over age 65 were covered by some form of health insurance at the end of 1963 (61 percent of the noninstitutionalized aged). Inasmuch as there were about 17.4 million noninstitutionalized aged at that time, an estimated 6.8 million were uninsured. Among these would be included most of the 2.2 million then on old-age assistance as well as those under the MAA program.

The reference to "about half the aged with commercial insurance policies covering hospital care have policies providing less than $10 a day for room costs" is from a study conducted by the Health Insurance Association of America. This study measured such coverage as of July 1961—almost 4 years ago. Since that time, many thousands of people over 65 have become insured under various State 65 programs, and individual company programs, which offer broad coverage (including coverage for major medical expenses). There is no doubt, therefore, that the proportion of the aged covered by insurance companies for hospital expenses, with policies of $10 a day or less for room and board, has decreased considerably since 1961.

It is of additional interest to note that about 18 percent of the insured aged in 1961 had more than one policy. The extent to which such duplicate coverage was present among policyholders with $10-a-day coverage is not known. It is generaly acknowledged, however, that the tendency to acquire additional coverage is more prevalent among persons with policies containing less extensive benefits.

Documentation for the comment that the aged have "very little coverage for other purposes" could not be found by the insurance associations. The statement is not in agreement with data developed by the Health Insurance Association of America. Such data indicate that at least 1.3 million aged persons had major medical expense coverage at the end of 1963. The association also found at that time that 82 percent of the aged covered for hospital expenses had coverage for surgical expenses and that 42 percent had coverage for regular medical expenses.

We are unfamiliar with the basis for the statement that "only about 1 in 20 have health insurance protection that covers about 40 percent of medical costs in their lifetime." Although we can make no comment on this statement, it is of interest to note that the U.S. national health survey has indicated that 82 percent of the insured aged discharged from hospitals during 1958–60 had more than half the hospital bill paid by their insurance and that 59 percent had three-quarters or more of the bill covered.

May I again express our appreciation of the opportunity to appear before the Senate Finance Committee. If we can be of additional assistance in these matters, please let us know.

Sincerely yours,

C. MANTON EDDY,
Senior Vice President.

ACTUARIAL ESTIMATES OF THE INITIAL AND LONG-RANGE COST OF BENEFITS UNDER PART B OF H.R. 6675, "SUPPLEMENTARY HEALTH INSURANCE BENEFITS FOR THE AGED"

It is the actuarial judgment of the insurance associations that the benefits of part B of H.R. 6675 will have an incurred cost of $7 per person per month in 1967 (the first full year of benefits under the program). It is the further considered judgment of the associations that these costs will inevitably rise during ensuing years. By 1990, (the 25th year of the program), the incurred cost will reach approximately $18 per person per month. The actuarial details of these estimates are presented on the following pages.

If 90 percent of the 19.4 million people over 65 in 1967 elect to enter the program, and under an assumption that each pays $3.50 (of the estimated cost of $7) per person per month with the Government matching this amount each month, the total cost to the Federal Treasury in that year, for this program will be $785 million.

By 1990, under the foregoing assumption as to equal cost sharing between the beneficiary and the Federal Government, and with 90 percent of the then 30.4 million people over 65 participating, the annual cost to the Federal Treasury will be $2,959 million.

Cost estimate for 1967

Based on data generally available from insurance companies, and employing the techniques used by actuaries in valuing the costs of major medical and other types of medical expense plans, the following was determined (before application of the deductible and coinsurance):

(1) The cost for surgical and anesthesiological services will be $35 per person per year. This estimate assumes that the level of charges will be equivalent to those experienced under policies with surgical schedule maximums of $500.

(2) The cost for in-hospital physician services will be $15 per person per year. This estimate assumes a hospital utilization rate of 3 days per person per year at a cost of $5 per physician visit.

(3) The cost for doctor visits at home and in doctors' offices will be about $50 per person per year. This estimate assumes that there will be an average of nine physician visits per person per year at a cost of $7 per home visit and $5 per office visit.

(4) The cost for the out-of-hospital services of radiologists, pathologists, and physiologists will be $5 per person per year. This estimate assumes that such costs will approximate 4 percent of the hospital per diem.

(5) The cost of home-care services, in 1967, will be $5 per person per year.

(6) The cost for psychiatric services, diagnostic X-ray and laboratory services and applicances will be $5 per person per year for each of these benefits.

Summary of costs of part B in 1967

	Cost per person per year[1]
Surgery and anesthesiology	$35.00
Doctor visits in hospital	15.00
Doctor visits in home and office	50.00
Radiology, pathology, physiology	5.00
Psychiatric services	5.00
Diagnostic X-ray and laboratory	5.00
Appliances	5.00
Home-care services	5.00
Total cost	125.00
Value of $50 deductible[2]	30.00
Net cost	95.00
Application of 80-percent coinsurance	76.00
Application of 10-percent administrative costs	7.60
Cost per person per year ($7 per month)	83.60

[1] All costs, with the exception of that for psychiatry and home care, are based upon experience under the Connecticut 65, New York 65, and Golden 65 insurance plans. Comprehensive insured lives experience do not presently exist with respect to the cost of psychiatry and home-care programs. For these benefits, therefore, the estimate is based on actuarial judgment and a review of the limited experience of such programs in a few areas of the country.

[2] It is assumed that 40 percent of the beneficiaries will have $50 or more per year in medical expenses; that 40 percent will have an average expenditure of $25 per year; and that 20 percent will have no medical expenses. Under these assumptions, the value of the $50 deductible is $30.

Long-range cost estimates

It is generally acknowledged that the cost of benefits under part B of H.R. 6675 will increase in future years. For this reason, the bill provides for a periodic review and adjustment of the adequacy of the premiums, based on the experience which develops.

Accurate forecast of long-range costs of medical expenditures are difficult because to the many underlying forces involved, many of which are unpredictable. Under assumptions as to cost trends which we regard as reasonable, the insurance associations have valued the long-range cost of the benefits of part B of H.R. 6675 under the following set of assumptions:

(1) The home-care benefit contains the greatest possibility for expansion and resulting substantial increases in costs. It is assumed that the claim costs of this benefit will increase by $0.82 per person per year (including administrative expenses).

(2) The cost of the other medical expense benefits, and the frequency of their use, will increase in future years as follows: 4 percent per year from 1968 to 1972; 3½ percent per year from 1973 to 1977; and 3 percent per year from 1978 on. These increases are somewhat lower than those predicted by the insurance associations (and the Social Security Administration) for increases in hospital costs under part A of the bill.

Under the foregoing set of assumptions, the cost will reach $218 per person per year by 1990 ($18 per person per month).

Level-cost estimates

The associations' level cost of the benefits under part B of H.R. 6675, during the 25-year period to 1990, will be 0.79 percent. Of additional interest, the insurance associations have valued the level cost of the benefits under part A of H.R. 6675 to be 1.54 percent of taxable payrolls. These level-cost estimates are based on (1) the assumptions of the associations as to the costs of the health care benefits and (2) the assumptions of the Social Security Administration as to taxable wage basis, population, interest, and rising earnings levels.

Mr. Eppy. Could I make a personal comment which I do not wish to saddle my trade association with, but in studying this new bill, H.R. 6675, Senator, I have found that I have been able to see more appreciatively some of the advantages of the King-Anderson bill than I have ever been able to see before. (Laughter.)

Senator ANDERSON. I am sure that will be the most appreciated statement you can make this morning so far as I am concerned. (Laughter.) On that happy note I will call on Senator Williams.

Senator WILLIAMS. Mr. Eddy, has the insurance company, your company, or any of the other companies, to your knowledge, made any estimate as of this time as to the actuarial soundness of part B of this bill?

Mr. EDDY. Well, perhaps, you are aware, sir, that over the years our estimates of costs, insurance estimates of costs, have seemed to run in excess of estimates of cost made by the administration. It is very difficult to price the benefits in part B.

As I recall, it has been identified by the administration that the level premium cost of part B is 0.49 percent of payroll. I think that the industry's estimates of costs would come out closer to 0.79 percent of payroll.

The great imponderable, one of the great imponderables, in the forecast of costs lies in the extent of the use of home care, which is a relatively new and untried field, and is unlimited under the provisions of part B.

Senator WILLIAMS. You are speaking of the supplemental insurance?

Mr. EDDY. Supplemental, I am sorry, sir. We have got A and B, and I am not sure whether it is A for Anderson and B for something else.

Senator WILLIAMS. How long do you think it would take for actuaries of your industry to come up with a reasonable estimate of the projected cost of that supplemental insurance program?

Mr. EDDY. At your request and the request of this committee, we would expedite it and do it to the best of our ability very quickly.

Senator WILLIAMS. Thank you.

Mr. EDDY. But an estimate of cost is no better than the basic assumptions. As we all know, we have to work with our best judgment on assumptions, particularly as they involve the future.

Senator WILLIAMS. Well, I appreciate that.

Senator ANDERSON. You go ahead and make the assumptions, but list what they are.

Mr. EDDY. We will, sir.

Senator ANDERSON. Because those are what are valuable to us, because we can take it back to HEW and say that these people assume that so many people will have a broken arm, and with a broken leg will be ill for period of time, and they can look at their figures and see if it sounds reasonable or not, and if you give us your assumptions we would very much appreciate it.

I want to join with Senator Williams and have you supply as much of that information as you can, because there is very little before this committee thus far—I do not know what the House committee had before it—which shows the actuarial soundness of what this bill does. I remember launching an insurance company some 37 or 38 years ago, and I had to backpedal as hard as I could to keep from getting too much business in the beginning and swamping it. I did not know how to operate it yet. It took me time to find out, and I assume it is the customary experience of the insurance business.

Mr. EDDY. It certainly is.

Senator ANDERSON. Therefore, we would like to have your experience, with a record of 100 years of service for the company, what it means in terms of this bill. Anything your company can do will be welcomed by me, at least, and I am sure by the members of the committee.

Mr. EDDY. We will do our best, I assure you.

Senator ANDERSON. Thank you very much, Mr. Eddy.

Mr. EDDY. Thank you.

Senator ANDERSON. Senator McClellan is here, and I want to have him introduce the next witness, Dr. Robins. Senator McClellan.

Senator MCCLELLAN. Thank you, Mr. Chairman and members of the committee. This is indeed a pleasure for me to have this opportunity to present Dr. Robins of Camden, Ark. Incidentally he is my neighbor and my family physician. I may say in that capacity he has sometimes prescribed an unpleasant but always very potent and effective remedy for my ailments and therefore, I think that his views and opinions anywhere, anytime in the field of medicine merit the most careful consideration.

For that reason, I am proud to present him, proud to present him also as the past president of the Arkansas Medical Association, and one of the founders and, I believe, the fifth president of the American Academy of General Practice. The doctor was one of the founders of that, and its fifth national president, I believe.

By the way, I think it would also be appropriate, certainly not too much out of line, to present him as a former national committeeman from Arkansas. He served for 8 years in that capacity as Democratic Committeeman from Arkansas.

I see you say you may be outnumbered here this morning, but that is still a good recommendation for me, and I hope it is for you. Dr. Robins.

Senator ANDERSON. Dr. Robins, we are very happy to have you.

STATEMENT OF R. B. ROBINS, CHICAGO, ILL.

Dr. ROBINS. Thank you, Senator McClellan.

Mr. Chairman and members of the committee, I would like to thank you very much for giving me the opportunity of appearing before you here this morning to present a short statement of my views as a physician on H.R. 6675.

As the Senator said, my name is R. B.—Bob—Robins, and I have been a medical doctor for 39 years. While my years have been devoted to medicine, I also treasure this opportunity for another reason. It gives me an opportunity to see old friends in these Halls, including members of this committee, and to renew ties dating back to the 8 very satisfying years I spent as a member of the Democratic National Committee.

As a matter of fact, I believe I enjoy the unique distinction of being the only physician who has served on the national committee of either major party in this century. I represented Arkansas on the Democratic National Committee from 1944 to 1952 and there worked closely with the leaders of our party. Today they are the leaders of Congress, holding in their hands the responsibility for the Nation's present and future well-being. Needless to say, I have only the greatest respect and warmest affection for all of them.

But it is as a doctor, as one of the 285,000 members of the medical profession in this country, that I speak to you now in vigorous opposition to a program of health care under centralized Federal administration, with wage earners compelled to finance "free" Government benefits for millions of Americans who do not need the assistance.

First, let me salute the committee for holding hearings on this legislation. Physicians cannot understand why this measure was not open for public comment before it went to the floor of the House of Representatives for a final vote.

This recent chapter in the legislative history of H.R. 6675 points up a situation which I believe should be noted here. Bills of this kind have been introduced in one form or another for 20 years but Congress has never seen fit to act favorably on any of them throughout that long period. If these proposals were wrong in the past—if there was reason for successive Congresses to reject them—they are still wrong. But now, this bill, the most sweeping one of all, is being rushed through to passage, and with hardly more than pro forma consultation with the medical profession, who will have to implement the legislation.

It appears that a long debate over a fundamental issue may be nearing an end. I believe it is reasonable to point out that physicians alone bear the ultimate responsibility for making this program work in whatever form it is finally enacted.

Your work on this matter will be done. You will turn to other issues of these times. Physicians will be left to contend day in and day out, month after month, with the terms of the legislation. They will be expected to go on providing only the best care while they strive to make sure the achievements of the past 25 years continue and multiply to the benefit of all mankind.

Most physicians do not believe this will be possible under the limitations and requirements imposed in the measure that is presently before you.

Surely their views and recommendations merit some serious consideration. It is unreasonable, in my opinion, to plunge ahead with the formulation of a program to which the great majority of members of the medical profession are opposed, both as to its expressed terms and its implied threat to the system of health care which this Nation has always known.

As you consider the action you are being asked to take, I urge you to remember that heretofore in the United States the health professions have been free to pursue their constant search for better methods of treatment, more effective drugs and more efficient techniques—unencumbered by the outside interference which is inescapable under a vast federally financed and controlled program. Under our system as we have known it, America has become the medical mecca of the world.

When I began medical practice, students who could afford it flocked to the medical centers of Europe for their basic and postgraduate education. Today, the reverse is true, medical students from all over the globe come to the United States to study and become finer physicians.

Yet, at a moment when American medicine is preeminent throughout the world, it is proposed that we adopt the very system under which

one European country after another has lost its former leadership in medical science.

There is no question, American physicians today are unsurpassed in their knowledge and ability. But what will happen when this seed crop is gone? Will the most talented young men and women continue to be attracted to medical careers when they see a profession falling more and more under Government supervision? I doubt it. Many of our best young minds will turn to pursuits where they can exercise their abilities to the fullest, to make the most out of their lives, without the stultifying effects of Government regulation. The loss of able entrants into the health-care field cannot help but lead to a deterioration of the quality of care in this country. I have personally observed this in England and other European countries.

The plan before you, of course, as I know that you know would cost a staggering sum. The administrative problems it would create would be enormous. But let these considerations be secondary for a moment. The important thing to perceive and understand is the disruption of the doctor-patient relationship that it entails; the time to be spent waiting in overcrowded offices and facilities; the beginning of the regimentation of medical practice of this country; the overburdening of medical facilities and personnel; the delays in admission to hospitals.

These are the perils which a physician sees in this proposal. I wish I coudl make you see them, too, so that someday they will not come back to haunt us all.

Before I conclude, there is another point in this bill to which I should like to address myself. That is the compulsory inclusion of self-employed physicians in the social security system.

I am 65 years old, the age for retirement written into the social security law. I am actively engaged in the practice of medicine and surgery, and expect to be so engaged for a good many years to come. In this I am typical, I think, of the overwhelming majority of physicians my age and older.

We don't stop practicing at any arbitrary age limit; our patients, I am happy to say, do not want us to. I can tell you from experience that they expect us to keep on serving them as long as we are able and for a great many physicians that goes well into the seventies. Any program built around a 65-year retirement age simply does not fit our career pattern. It is unnecessary and unwarranted to force us into a system designed for persons in other callings where similar pressures do not exist to continue working into the latter years of life.

I urge you to delete this section from the bill.

In this brief testimony, I have tried to communicate, as a physician, my very deep and very sincere reasons for objecting to the passage of H.R. 6675. Medicine has been my life. I don't want to see it harmed—for the sake of the profession and for the sake of Americans of the future.

Time has not permitted me to go into specifics. But in the many hours of testimony here, you will receive a great many detailed objections to the terms of the bill from spokesmen for medical organizations throughout the country. I urge you to heed them.

I urge you to give serious consideration to the physicians' plan for meeting this problem, and the physicians have a plan called the elder-care program with which I am sure you are all familiar.

I urge you to reject H.R. 6675 and, in its stead, to write legislation which will fill the needs of all those who cannot take care of themselves, and at the same time will preserve the vitality and promise of our health care system.

Let me again express my appreciation for the opportunity to be heard on this important piece of legislation this morning. Thank you, Mr. Chairman.

Senator ANDERSON. Doctor, the dentists came in a few years ago after being out for quite a while. Have you heard any dentists objecting to the fact that they are in the program?

Dr. ROBINS. Yes, I have, Senator, many of them. They failed to raise their objection as they should, and that is what I hear many of them saying today.

Senator ANDERSON. So many of them have indicated to some of us, at least, that they were forced to object to it, but now they are very well pleased to be in it. Lawyers are in, aren't they? They practice beyond 65 a great deal.

You indicated that this has been sort of a long struggle, and these proposals have been turned down in the past because they were wrong and they ought to be turned down now. You are familiar with the fact that the Senate passed the bill, aren't you?

Dr. ROBINS. Sir?

Senator ANDERSON. You are familiar with the fact that the Senate passed the health care for the aged?

Dr. ROBINS. Kerr-Mills bill?

Senator ANDERSON. No; they passed another one called the King-Anderson bill in 1964.

Dr. ROBINS. Yes, sir.

Senator ANDERSON. Did anybody give them a chance to vote on it in the House? I do not think the House thought it was wrong. They couldn't get it out of the Ways and Means Committee.

Dr. ROBINS. You have here a three-layer cake which the Ways and Means Committee did not give the public an opportunity to express themselves on.

Senator ANDERSON. They had so much publicity by the doctors charging that they did not put enough in the King-Anderson bill. We are happy to have you testify today, we are happy to have you under such sponsorship as that of Senator McClellan.

Dr. ROBINS. I rode over with Senator Douglas.

Senator ANDERSON. Senator Douglas.

Senator DOUGLAS. I want to say that we are very glad to welcome Dr. Robins. We are very glad he left Arkansas and came to Illinois. I hope he changes his views on this bill, and I hope the Senator from Arkansas won't take offense when I say his movement indicated good sense on his part.

Senator MCCLELLAN. Doctor, you have not changed your voting residence, have you?

Dr. ROBINS. Senator, I hate to admit that in public, I have not. I am still a voting resident of Arkansas.

Senator DOUGLAS. That may be an addition to the Democratic Party of Illinois.

Senator ANDERSON. Senator Williams.

Senator WILLIAMS. No questions.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. Doctor, I appreciate having your statement. Are you familiar with the position of the pathologists and radiologists and the psychiatrists?

Dr. ROBINS. Yes; I am somewhat.

Senator CURTIS. If this bill were to be passed, is it your belief that they should be placed over in part B where all physicians are as contrasted to the hospital section?

Dr. ROBINS. Yes; I think the pathologists and radiologists and anesthesiologists should be placed where the other doctors are, excluded from hospital employment.

Senator CURTIS. And you think that it goes beyond a mere problem in bookkeeping or accounting or anything of that sort? You think there is a very good basic reason for it——

Dr. ROBINS. That is right.

Senator CURTIS (continuing). From the standpoint of the practice of medicine?

Dr. ROBINS. Yes, sir.

Senator CURTIS. That they should retain their status as independent practitioners?

Dr. ROBINS. Certainly.

Senator CURTIS. Do you think that is better for the patient and better for our health system?

Dr. ROBINS. Yes, sir.

Senator CURTIS. That is all, Mr. Chairman.

Senator ANDERSON. Thank you very much.

Dr. ROBINS. Thank you.

Senator ANDERSON. In lieu of testifying in person Congressman Durward G. Hall is submitting his written statement for the record. It is being placed in the record at this point.

(The statement follows:)

STATEMENT OF HON. DURWARD G. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Chairman, I come before this committee both as a Member of Congress, and as a physician—a member of the profession which is deeply and inextricably involved in the great issue before us.

I am speaking for a system of health care, which is universally recognized as the finest in the world. As a physician, I could not have a greater opportunity or responsibility. As a Representative in Congress, one must be delving, perceptive, informed, and decide judiciously.

The members of the medical profession, of which I am one, believe we have a responsibility to call to the attention of the public, our patients, any projected development which threatens the quality of medicine in this country.

On doctors falls the ultimate responsibility for treating the sick, overcoming disease, and assuring that medicine's achievements of the last 25 years will continue and multiply to the benefit of all mankind. It will be their task when the tumult and the shouting on this issue dies and Congress turns to other questions of the hour, expressed in the vast store of bills awaiting its consideration.

The question is not the care of senior citizens, but how best to assure them needed quality care. Physicians are the ones who will be expected to go on providing "only the best" of medical care, tailored to fit individual needs, to which Americans are accustomed, and which they properly demand. In the last analysis, they are the ones who must contend directly with this program and try to make it work.

Consequently, we cannot stand idly by now, as the Nation is urged to embark on an ill-conceived adventure in Government medicine, the end of which no one can see, and from which the patient is certain to be the ultimate sufferer. For make no mistake about it: The medical profession will never deprive the people of high-quality medical care and the fruits of progress of medical science. That

will come when the Government begins meddling and interfering with medical freedom.

What are some of the factors which, added together, clearly point to a deterioration of health care under a program of Government-controlled medicine for any segment of the population? Let me list a few:

First. The basis for quality medical care is the voluntary relationship between the doctor and his patient. This would begin to disappear as Government supplants the individual as the purchaser of health services.

An obvious attempt has been made in this legislation to conceal the grant of power which would be extended to the Secretary of Health, Education, and Welfare to interfere with administration and medical practice in participating hospitals. But the power is in the bill, and its use by Government employees in carrying out their responsibilities toward the expenditure of Government funds cannot be doubted.

The result would inescapably be third-party intrusion in the practice of medicine. The physician's judgment would be open to question by others not responsible for the patient's well-being. His diagnostic and therapeutic decisions would be subject to disapproval by those controlling the expenditure of tax money. Paradoxically, his cooperation is required for proper function and certainly to avoid the abuse factor.

Second. As the Government fixed prices for service rendered—as indeed it must to protect the public purse—financial incentive would begin to melt away.

Third. The incentive of competition with one's peers, invariably the spark which ignites the flame of creative progress, would also fade since rivalry would be eliminated by virtue of centralized direction, be it practice or all-important bedside research.

Fourth. As physicians and health facilities become more and more subject to intervention in their work by Government employees, a decline of professionalism would be certain.

Fifth. The overutilization and abuse of a "free" service to which everyone had a "right" would result in increasing physician harassment which could not fail ta lead to a form of medicine abuse factor and bed occupancy alien to these shores—medicine on an assembly line basis.

Sixth. Quality medicine would be dealt a further blow by the loss of able entrants in the health field because young men, viewing a profession under partial or total Government domination, could be expected to seek careers in other fields.

These things will not happen tomorrow, or the day after, or the next week, or next month. But as surely as the tides move in Chesapeake Bay, they will come if this measure is enacted into law.

America today has the finest physicians and scientists in the world—a fact frequently demonstrated over the last decade when the Nobel Prizes have been handed out, or by your life expectancy, or by those seeking postgraduate training. These intelligent, highly trained, superbly skilled men and women will continue to serve the health needs of the Nation, and because they are professionals, who have devoted their lives to this system of ours, they will continue to do the best they can, no matter what adverse conditions they are suddenly confronted with.

But what happens when this seed crop is gone? I suggest you look across the Atlantic for an answer. The other night I heard this sentence in a Chet Huntley broadcast discussing the current struggle between physicians and the Government in the British National Health Service:

"Britain has been losing doctors at the rate of almost 500 a year. The number of medical students is declining, and already below the level of 1938. Meanwhile, the population grows."

You see, there are some things which cannot be handled by a law. Men bred in freedom learn to like the taste of it. Few engineers would want a government employee telling them how to draw a line. Most bookkeepers, I suspect, have little desire for advice from Washington on how to add a column of figures. I have yet to meet a lawyer who has spoken of his desire to have the legal profession brought under the surveillance of the Department of Justice.

It is as simple as that. This is not merely a controversy over whether Government should tax one group of citizens to provide health care benefits indiscriminately, regardless of need, to another group. This is not merely a disagreement over the best means of providing health care for our older citizens. Rather, this conflict is testing again whether the art and science of medicine will be permitted to grow and flourish in freedom, or whether progress in medicine will be stunted and shriveled by an excess of Government control, third-party interference.

Here let me nail down one of the most patent falsehoods that has been uttered by proponents of H.R. 6675 in their campaign of abuse and villification against the whipping-boy medical profession. This is the whispered charge that doctors are "really against the program because it would affect their income; that their fees would somehow be reduced by the Government."

Nothing could be further from reality. Doctors' incomes would probably be more assured, not less, if this bill is enacted. Anyone knows there is more money in mass production. It is principle, freedom, research, and insurors who will suffer.

Seventeen and a half million older citizens would become eligible for hospitalization, nursing home, and home nursing care, financed from the Federal Treasury. Those lured to take advantage of the program by the prospect of a "free" benefit would need a physician's certificate to enter a hospital. Physicians would be expected to care for them while they were in hospitals or nursing homes. Who can say how many new patients physicians would acquire as a byproduct of this legislation? It is safe to say the number would be sizable.

But that is really beside the point, or at least only a tangent. The American system of medicine is a system of quality medicine, not mass production or assembly line medicine. It is a system of private medicine, practiced by private doctors treating private patients, free to make decisions based on the patient's specific medical needs and nothing else, except a confidential relation—privileged, if you please.

Forget for a moment the cost of staggering, though uncertain, proportions of the program before us. Ignore the administrative problems that it would create, and the burden it means for wage earners at the low end of the income scale. Neglect the new bureaus we are entailing.

Look only at the intrusion of Government in the field of medicine, which cannot be avoided, which goes hand in hand with this plan—the regimentation of hospital admission and discharges, arbitrary limitations on nursing homes available to care for aged patients, and the implicit responsibility placed on hospitals and physicians to keep the cost of this program under control.

Bureaucratic regulation cannot be mixed with medicine without diluting the quality of medical care any more than gasoline and sugar in the modern combustion engine. In this case, furthermore, the availability of medical services to the aged would be governed by the availability of tax money, not by the medical needs of these citizens. If quantity is thus restricted, quality would inevitably suffer.

Under our system as we have always known it, treatment of the individual comes first, and financing second. It is the patient, in the role of the customer, that exacts the utmost from the doctor-patient relationship through his ability to choose freely.

The physician, in turn, responds to this show of confidence by the exercise of his knowledge and skill to his greatest capacity, guided solely by what is best for his patient.

This is not a public works project of stone and steel that we are dealing with, or the purchase of overcoats for the Army. This is a fragile, perishable relationship, perhaps the most delicate in all human ties, and founded on American tradition and principle. It cannot withstand third-party tampering without serious harm. Are we to callously overthrow it by legislative process?

Should the Government become the customer—the outside party striving to reconcile the demands of the patient for high quality care and the demands of the taxpayers for efficient use of tax funds—the emphasis must shift from quality to cost. The Government can resolve these conflicting demands in only one way. It must tighten the reins on services to keep them within budgetary limitations; either that, or the Department of Health, Education, and Welfare must be repeatedly pleading with Congress to bail out the program with higher payroll taxes.

Doctors want to continue to be free to give patients the best advice and the best treatment they are capable of giving, without the pressure of outside considerations that have nothing to do with the quality of health care. They oppose any course of action which threatens the professional independence of the physician and imperils the wholly voluntary relationship which now exists between doctor and patient, thereby striking at the heart of our magnificent health care system which has accomplished so much for mankind in an atmosphere of freedom.

If this legislation is enacted, the aged would be the first to feel its effects on the quality of health care. But is it possible for health care to operate in one way for

one segment of the population and in a different way for everyone else? The question answers itself. This is our first venture into providing service in lieu of cash benefits on a payroll deduction tax basis. What of the further effect of devalued dollars and inflation on these senior savers who secured their own future?

One serious shortcoming in the bill approved in committee is that the abuse factor has not even been considered, much less, compensated for. Yet, we know now that this factor of abuse is what accounts for the severe crisis now confronting both the British and French systems of government medicine. Many more patients will be admitted to hospitals for diagnostic services under this bill, far more than ever before.

The bill apparently will depend on doctors to maintain hospital turnover, even though they will have less practical authority to carry out this responsibility, under the bill.

We all realize that the average length of hospital stay under this bill is certain to increase and the sum total will be that proportionately fewer and fewer private patients are going to be admitted as more hospital beds are occupied by persons eligible for free care under this bill.

Most certainly after this bill becomes effective, it will require a crash program of hospital construction under Hill-Burton, as well as another crash program of nursing and convalescent homes.

The $64 question in most people's minds is bound to be, "Will doctors participate?" Of course, it will take time to implement and the answer will be partly determined by how this is done. A new fee schedule and signup of doctors who will participate will be a first order of business.

I predict that American physicians will sign up and participate because they are first of all humanitarians, imbued with the mission of serving people.

Perhaps the most incredible part of this whole operation, has been the utter disregard of the doctor's viewpoint by the social engineers who drafted this four-layer cake. This in spite of the fact that the program cannot possibly work without the cooperation of the doctors (13th amendment, neglected or voided in considerations.)

It might be compared to building a space satellite without engineers, or developing a space satellite without engineers, or developing a battle plan without consulting the Joint Chiefs of Staff. I cannot help but wonder what Walter Reuther might say if the doctors should recommend that collective bargaining agreements be made up by business alone without consulting labor.

That is exactly what we have under this bill. Without he doctor, this bill is nothing more than 300 pages full of words signifying nothing. Yet, at no time during the week this bill was drafted, were the Nation's doctors asked to contribute to the deliberations or to comment upon the feasibility of the bill insofar as they, their professional skill, and their ability and willingness to serve is concerned. This decision to ignore and even belittle the practicing physician, whether it was made by President Lyndon Johnson, or Wilbur Cohen, or Mr. Celebrezze, or by the majority members of the Ways and Means Committee, will stand in the record as the most brazen act of omission ever committed on a piece of major legislation. It will have its reverberation for as long as anyone of us is privileged to look into the future.

As a physician whose lifetime of service in his profession has meant a very great deal to him, I can only ask you to pause and reflect and weigh this issue with prayerful consideration. It is not a simple matter. Of this, we are all aware.

But, on balance, when you decide, I hope you will be thinking of the next generation of Americans and all those who will come afterward.

Senator ANDERSON. Our next witness is Dr. Rooke.

STATEMENT OF RALPH R. ROOKE, FORMER PRESIDENT, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS; ACCOMPANIED BY SIDNEY WALLER, COUNSEL

Mr. ROOKE. Mr. Chairman and members of the Senate Finance Committee, my name is Ralph R. Rooke. I am a resident of Richmond, Va., a registered pharmacist, and have been actively engaged in the

ownership and management of a retail pharmaceutical business in Richmond for 36 years.

It has been my privilege and honor to serve as the president of the Virginia Pharmaceutical Association and as president of the National Association of Retail Druggists. I appear before you as a representative of the National Association of Retail Druggists.

I would like to introduce a gentleman that I have with me as our legal counsel, Mr. Sidney Waller. We have back in the room our executive director, Mr. Willard Simmons, and our Washington representative, Mr. Joseph Cohen.

You may already be aware that the National Association of Retail Druggists, which I shall hereon identify as the NARD, is an association serving the professional and business interests of a nationwide membership comprised of more than 36,000 independent drugstore owners operating in excess of 41 thousand of the Nation's 54,000 drugstores. The NARD, which has been in existence for 67 years, speaks for practicing retail pharmacists on all national legislative matters which have a professional or economic bearing on their sphere of activity.

I should like to begin by complimenting those whose interest in the health situation of our elderly citizens provided the stimulus for bringing this important matter into the focus of public attention. Certainly the profession of pharmacy has long been intimately aware of many of these problems. The exposure which a retail druggist has to the proposed beneficiaries of the medicare program is both intensive and extensive. As the major source for medicines required to manage many of the continuing afflictions of old age, a retail druggist sees the plight of these people at firsthand.

Credit records in drugstores throughout America will attest to the fact that retail pharmacists are also cognizant of the economic difficulties which face some of these oldsters. Thousands of prescriptions are filled for them every month with little or no hope of payment. To this extent it can be said with justification that the Nation's pharmacists preceded Congress in attempting to make a positive contribution to the dilemma of precarious health and limited resources which face a sizable group of our older citizens.

You may be sure that retail druggists solidly endorse the objective of not permitting economic considerations to deprive an older person of the professional attention and related health services which he requires to cope with transient or chronic illness. It is difficult, for that matter, to conceive of any reasonable person arguing with such an objective.

In the American aspiration of life, liberty, and the pursuit of happiness, life is preeminent. To protect life is to protect health, and the protection of health calls for management of disease, sickness and the more chronic infirmities of old age. The independent retail druggists of America, I assure you, endorse and share the humanitarian considerations which underpin the medicare proposal now before you. We have studied the draft bill carefully and in some particulars feel its provisions can and should be strengthened. Our appearance before you is motivated by this interest.

We hope to make a positive contribution to the fashioning of a program which will accomplish its central purposes without endangering what we equally believe to be important considerations in related areas.

The independent retail druggists are most appreciative of the opportunity your committee has afforded us to state our views.

We suggest the amendment as follows to section 1861(t) under drugs and biologicals:

Section 1861(t) defines the term "drugs" and the term "biologicals" to mean—except for purposes of the exclusion of drugs and biologicals under home health services—those drugs and biologicals which are included in the United States Pharmacopeia or the National Formulary, or in New Drugs or Accepted Dental Remedies—except for any drugs and biologicals unfavorably evaluated therein—all of which are to be dispensed by a pharmacist authorized by a State to practice pharmacy.

The purpose of the amendment to drugs and biologicals section 1861(t) is:

1. To provide qualified professional personnel to distribute the drugs and biologicals provided in the act.

2. To uphold and maintain the high standards of the pharmaceutical profession.

3. To enhance the welfare of the public who may be recipients of the benefits under the act in connection with drugs and biologicals.

Mr. Chairman, I have a supplemental statement which has been submitted to be added at this point.

Senator ANDERSON. Without objection, it will be added there.

Mr. ROOKE. In conjunction with the purposes of the amendment to section 1861(t), defining the term "drugs" and "biologicals," we have excluded "or as are approved by the pharmacy and drug therapeutic committee [or equivalent committee] of the medical staff of the hospital furnishing such drugs and biologicals."

The inclusion of this language in the law gives Federal sanction to a device known as "formulary dispensing" associated with the doctrine of "prior consent" whereby a committee of the hospital staff prepares a restricted list of drugs available which all physicians of the hospital are expected and, in many instances, required to subscribe to in their treatment of the hospital patients. One of the results is that useful drugs may be eliminated from those a physician requires for his elderly patient.

Traditionally, the various States, through the various pharmacy boards, regulate the practice of pharmacy. The "formulary" with the "prior consent" doctrine suggests that "substitution" of a trade name brand is permitted even though most, if not all, of the State pharmacy laws prohibit such practice by the pharmacy profession, which, of course, must include hospital pharmacists. If such language is not changed, the law would create two standards in dispensing drugs—one, under medicare; the other, for pharmacists serving the public outside of the medicare program.

The language of section 1861(t), without the objectionable inclusion of the "formulary" and "prior consent" doctrines, is sufficient in itself to cover all such drugs or biologicals that may be necessary for proper treatment of the public. The use of the added phraseology merely provides intrusion in an area more adequately provided for in the laws of the various States.

The additional language we have suggested, "all of which are to be dispensed by a pharmacist authorized by a State to practice pharmacy," is a recognition by the Federal Government of the actual status under the laws of the various States. We are confident that this committee,

and all other committees of the Congress, intends that dispensing of drugs must be under the professional control of a pharmacist. Otherwise there will be a tendency to depreciate the high standards of the pharmaceutical profession.

It is true that a large proportion of our older citizens are beyond their productive years and out of the employment market. On the other hand, large numbers of people eligible for social security benefits are able to pay for their own medical care.

Our national tradition of self-reliance strongly urges that, to the greatest extent possible, an individual should fulfill his own requirements. The concept applies with equal force whether in the health field or as concerns food, clothes, housing, or what have you.

We urge the committee to give serious consideration to a screening process of some kind, which would provide a measure of assurance to the taxpayers who are to support it, that medicare payments are being disbursed in line with reasonable public prudence.

REQUIRED INSTITUTIONALIZATION

Definitions and explanations used in the draft version of this bill lead to the inescapable conclusion that obtaining benefits under its provisions will, at the outset, call for the individual's admission to a hospital.

After a hospital stay of greater or lesser duration, as spelled out in the bill, transfer might be accomplished to a secondary institution equipped to provide domiciliary attention with some nursing service available, as required.

After having exhausted entitlement to the services of the secondary institution, or being discharged from it due to physical recovery, the patient may then be entitled to certain home care benefits and assistance, as needed. Additionally, the proposed legislation appears to envision and authorize out-patient attention at designated clinics or other treatment institutions offering this class of service.

Insofar as the individual patient is concerned, however, admission to a hospital or other treatment establishment seems to be the inescapable first step in obtaining beneficiary status for primary, secondary, and ancillary services under the enabling act.

We believe the procedure as broadly spelled out in the draft bill is unrealistic as related to the practical health care needs of many of these older people. We furthermore believe the first effect of the institutional requirement will be a staggering influx of patients to already overcrowded and understaffed hospitals. The economic enticement offered in the present medicare draft will be, at best, hard to resist and, while we might hope that hospital admissions will not be accomplished unless the patient is actually in need of such care and attention, experience in Veterans' Administration hospitals and under such programs as Blue Cross clearly demonstrates that when hospital admission is required for validating a collateral claim, hospital admission will be obtained.

Senator ANDERSON. Could I stop you there a second and ask in the case of the veterans facilities, is there a deductible of $40?

Mr. ROOKE. Is there a what?

Senator ANDERSON. Is there a deductible of $40? Don't you think the deductible that is in the bill might tend to curb some of that?

Mr. ROOKE. I do not believe I quite hear you.

Senator ANDERSON. You are looking for a great influx into the hospitals because it is free.

Mr. ROOKE. Yes.

Senator ANDERSON. Suppose there is a $40 deductible they have to pay first, will that cut down the influx?

Mr. ROOKE. Yes, sir; to some degree, but I think there is still going to be an influx into those hospitals—I am sorry, I did not get that, Senator.

Senator ANDERSON. Yes. You are worried about what has happened in the veterans facilities, and what the experience in the Blue Cross demonstrates. The veterans facilities don't have any deductible, do they?

Mr. ROOKE. No.

Senator ANDERSON. If you are entitled to come you are entitled to come.

Mr. ROOKE. Yes.

Senator ANDERSON. And many of the Blue Cross programs don't have any deductible, most of them, in fact. Do you think it is a fair comparison to this bill?

Mr. ROOKE. I think that any contract of the kind that requires hospitalization is necessarily going to have an influx of that requirement to get this, to receive these benefits. Our hospitals in our part of the country are already overcrowded. We have, in Richmond, about 4,000 hospital beds, but it is very difficult to get a hospital bed now.

Senator ANDERSON. All right.

Mr. ROOKE. Many, if not most, of the health problems in old age are of a chronic and continuing nature rather than separate episodes of acute illness.

Arthritis, heart conditions, respiratory difficulties, and organic malfunctions, some or all of which seem to plague the advancing years of most of us, require some sensible restraints on the part of the patient and a continuing regimen of drug therapy to support the malfunctioning structure or otherwise manage the problem. People suffering from conditions of this kind need the periodic attention of an attending physician and the pharmaceutical preparations their condition requires. A great many of these conditions can be and are satisfactorily managed in the patient's own home. This statement is subjectively proven by the countles thousands of such patients who see the inside of a hospital only rarely, although they are victims of a chronic disability for years, sometimes decades.

We believe the medicare program can provide a serious disservice to many of these patients if its provisions demand they submit to institutionalized treatment in order to avail themselves of the other benefits of the program. We think the best interests of the patient are served by maintaining, insofar as possible, his normal living patterns. We think, to the greatest extent possible, these older patients need to maintain their status as functional members of their families. The medicare program should put high priority on protecting such family relationships.

We believe the attending physician should be the final authority with respect to what justifies the best care for a particular patient. Hospitalization should never take place as an administrative expedi-

ent nor as a result of direct or indirect economic enticement. Unless institutional care is actually required by medical circumstances and confirmed in the judgment of the physician in the case, it represents economic waste and a gross disservice to the patient.

The National Association of Retail Druggists urges the most careful reevaluation of this matter.

FACILITIES AVAILABLE

It may come as a surprise to learn that despite our national population approaching the 200 million mark, the United States is still a nation of small towns. The 1960 census listed only 130 American cities with populations over 100,000. More than 30 percent of our total population resides in rural rather than urban areas and a disproportionately large number of older people live in the rural areas than in metropolitan areas. This latter fact may be either a testimonial to the healthy, country atmosphere or the physical exercise which farm activities entail, but the statistics are clear: there is a higher percentage of farmers who are old than of bankers or pharmacists.

Statutory entitlement to outpatient services in a medicare-accredited institution will only be of academic interest, unless the institution is in some reasonable proximity to its potential user. Travel is one of the most difficult engagements for disabled oldsters. In a given situation, faced with the alternative of twice weekly visits to an outpatient clinic 40 or 50 miles away, or of admission to a hospital for bed care, the patient might well choose bed care purely because it would entail less inconvenience for the family and substantially less stress on the patient himself.

EQUALITY UNDER THE LAW

Equal treatment under our statutes is basic to the American concept of democratic procedures. However, treatment facilities are not equally distributed across the geography of this Nation. Even granting that there may be sufficient institutions to accommodate all of the medicare recipients who would wish to qualify as beneficiaries, the difficulties involved in reaching the closest such institution would, for some of them, be enormous. Some people have proposed the creation of specialized institutions for the diagnosis and care of medicare patients. The costs of such a program would be monumental in themselves, but the strongest arguments are to be found in the area of their limited usefulness as integral elements in our national health facilities.

The National Association of Retail Druggists takes the position that the most effective means for providing health care for our aged citizens is to be found in making maximum use of existing treatment institutions, professional practitioners, and ancillary services.

We believe that, except for the interdiction of Government as a guarantor that economic limitations are not allowed to deprive our old people of health services they need, all other considerations should be dealt with, as far as possible, in the existing health facilities of a given State, locality, or community.

Such a procedure will save the program from charges of either managing or unduly manipulating medical activity. It leaves the respon-

sibility and the prerogatives for developing adequate health facilities where they belong, in the hands of the people who are in a position to appraise area needs and array them against available economic, professional, and civic abilities from personal observation, experience, and involvement.

CONCLUSION

The National Association of Retail Druggists believes the American medical community has demonstrated a superior professional ability and a laudably humanitarian concern with the health of this Nation. We think there is no lasting benefit to be obtained by supplanting the services of existing institutions with different kinds of institutions. We think there are no benefits to be gained, and substantial hazards to be calculated, in supplanting the attention of a patient-selected physician with a program-authorized physician in a designated institution. We believe that, second only to the services of the physician himself, drugs are among the most important considerations in managing the physical infirmities of the people who will inescapably be known in the future as medicare patients.

We believe existing hospitals, doctors, and pharmacies constitute the first line of defense against disease and illness of all kinds, at whatever age it might assert itself.

Finally, we believe that humanitarian considerations, economic realities and the best interests of the beneficiaries under this program, support the idea of utilizing existing practitioners and institutions to the maximum extent. Creation of additional facilities should be undertaken only in the face of urgent, well-demonstrated need.

To these ends the National Association of Retail Druggists urges this committee and Congress as a whole to pass no law or adopt no procedure which will unduly restrict patient choice or professional function. Since this program is prompted by humanitarian considerations, it should assiduously shun the imposition of program mandates for personal desire. If medical care can be extended to the aged only at the sacrifice of their personal freedom, then the price is too high. If this program intends to meet the familiar tests of economic responsibility, it should be painstakingly designed to offer the fullest extent of flexibility consistent with prudent management of public funds.

And, last of all, this program has the opportunity to make a positive contribution to the overall health of our Nation and to the vigor and viability of the American business system. To do so it must avoid interposing functional classifications or geographic distinctions which will unequally confer advantages on some while depriving others.

Our existing health facilities are national in scope and proportionally distributed. Any national program in the field of health should begin with knowledge and appreciation of this fundamental resource and then direct its attentions to more efficient utilization of the many elements which comprise the Nation's health facilities, already extant.

Senator ANDERSON. Doctor, you say:

We think there are no benefits to be gained, and substantial hazards to be calculated, in supplanting the attention of a patient-selected physician with a program-authorized physician in a designated institution.

Do you find anything in the bill which says a man cannot have his own doctor?

Mr. ROOKE. I do not think so, Senator.

Senator ANDERSON. What do you mean by "patient-selected physician with a program-authorized physician"? You can answer, you have been identified for the record, Mr. Waller.

Mr. ROOKE. We feel that some of these older people have their own physicians who have been treating them for years, and that they should be allowed to be treated by that same physician rather than those who may be designated by the hospital.

Senator ANDERSON. What do you find in the bill that would stop them?

Mr. ROOKE. Well, we are afraid that there might be, some way, a program-selected physician rather than a patient-selected physician.

Senator ANDERSON. Point to the language, will you please.

Mr. WALLER. Mr. Chairman, actually what we are pointing out here is that we are in agreement with the philosophy of the bill in the sense it does not do this.

Senator ANDERSON. Thank you. It was not apparent from the language.

Mr. WALLER. That was our conclusion. It was not a statement of fact by any means. We agree with this principle.

Senator ANDERSON. Thank you.

Senator Bennett?

Senator Curtis?

Senator Douglas?

Senator DOUGLAS. This point leads me to ask another question. You pay tribute to the humanitarian purposes behind the bill, and then you lay down a series of general considerations which you think ought to be included, with most of which, if not all, I find myself in agreement. But somehow, you give the impression and the implication that the bill does not meet these considerations.

As the Senator from New Mexico has pointed out, the provision for the deductible is intended to diminish any tendency to use the hospitals unduly, and very certainly there is a free choice of physician rather than a dictated choice of physician under the supplementary plan. So I want to come to another question. Do you support the bill in its present form or are you opposed to the bill?

Mr. ROOKE. We are in agreement with the humanitarian concepts of the bill, Senator.

Senator DOUGLAS. Suppose you are a Member of the Senate. Would you vote for the bill in its present form or would you vote against the bill? The druggists are a very powerful force in the country not only because of their good service but also because of the general influence which they have on their patrons. In the present form would you vote for the bill?

Mr. ROOKE. Senator, I think, speaking personally only, I would vote against it in its present form.

Senator DOUGLAS. You would vote against it.

Mr. ROOKE. In its present form.

Senator DOUGLAS. Now, let me ask you this question. Section 1861 (t) gives the definition of drugs and biologicals. You quoted it in your statement. Do you find that definition satisfactory or would you like to have it changed?

Mr. ROOKE. We were suggesting, Senator, some changes here, I believe, in our supplemental report.

Senator DOUGLAS. Yes. What specific changes do you recommend? You inserted those with your testimony.

Mr. WALLER. We are suggesting there should be amendments to the definition of drugs and biologicals.

Senator DOUGLAS. Yes. But what type of amendments?

Mr. WALLER. We are suggesting that part of the language that is there is inclusive enough. The purpose of the amendment, as we see it, should be that the doctor should have the opportunity to prescribe what drug he thinks is necessary for his patient.

Senator DOUGLAS. What is practically involved in this? Is this a question of the brand names? Would you like to have the brand name drugs included?

Mr. WALLER. Part of it may very well be the question of brand names, as to the fact that if a doctor believes a certain brand is better than a generic, that he may think of, then he should have the right to rely on that brand.

Senator DOUGLAS. That is, to prescribe Anacin and Miltown?

Mr. WALLER. Yes, possibly, Miltown, Anacin.

Senator DOUGLAS. Is it true that the contents of these brand name drugs are identical with the generic terms used in the U.S. Pharmacopoeia or the National Formulary?

Mr. WALLER. Well, there is quite a history based on what is meant by therapeutic equivalents and generic equivalents. In fact, the Government itself, the FDA, does not agree that there is such a thing as generic equivalent completely.

Senator DOUGLAS. Is it true that the chemical composition of many of these preparations, such as Miltown, Anacin, and the rest, are identical with the generic definitions given in the U.S. Pharmapoeia?

Mr. WALLER. Senator, it cannot be answered on that basis alone.

Senator DOUGLAS. Please answer my question. Is it true that the chemical composition of these products sold under brand names is identical with the generic terms as covered in the U.S. Pharmacopoeia?

Mr. WALLER. Not necessarily completely because there may have been certain items in there, buffering compounds, certain sustaining compounds, certain catalytic compounds that will make a difference in the type of product that you are using.

Senator DOUGLAS. Is Anacin, for instance——

Mr. WALLER. I do not know the exact composition of Anacin.

Senator DOUGLAS. Is it not true that it is identical——

Mr. WALLER. With what?

Senator DOUGLAS (continuing). With the definition of a multisyllabic compound listed in the U.S. Pharmacopoeia?

Mr. ROOKE. Senator, the Pharmacopoeia allows a variation one way or another, and the generic may be 5 percent in some and maybe as much as 7 percent in some stronger, under or over, whereas the brand names are standardized in strength.

Senator DOUGLAS. Is it not also true while there is either no difference or insignificant differences in the chemical composition, that there is a tremendous difference in the price?

Mr. ROOKE. Yes, sir. That is correct in some instances.

Senator DOUGLAS. In some cases the price of the branded article is 10 or 15 times the price of the chemical compound, isn't that true?

Mr. ROOKE. There are a lot of physicians who adhere to the brand names, and personally as a pharmacist, I have confidence in them.

Senator DOUGLAS. Traditions.

Mr. ROOKE. Yes, sir. A personal note, personally, myself, I do, too, if I am sick. I want to be on the mark, not a variation.

Senator DOUGLAS. You are a registered pharmacist, are you?

Mr. ROOKE. Yes.

Senator DOUGLAS. And you are able to tell what the chemical compositions of these compounds actually are, isn't that true?

Mr. ROOKE. We could if we took the time to analyze it.

Senator DOUGLAS. So you are able to look behind the brand names. You do not have to mix these compounds, do you?

Mr. ROOKE. No.

Senator DOUGLAS. You can purchase them wholesale.

Mr. ROOKE. Many of them, most of them, are already compounded.

Senator DOUGLAS. It makes a great deal of difference in price. You have seen the comparisons.

Mr. ROOKE. There is also a great deal of difference in the stability of some of these products, the life of them, the brand names seem more stable.

Senator DOUGLAS. Is the life of the brand named product longer than the life of the chemical product?

Mr. ROOKE. Yes.

Senator DOUGLAS. Have you proven that?

Mr. ROOKE. We have seen it in those preparations on our counters where some generic drugs become discolored or develop an odor, decompose to some extent, we have seen that.

Senator DOUGLAS. Thank you.

Senator ANDERSON. What you have said here is you want that portion taken out that permits approval by the pharmacy and drug therapeutic committee of a hospital. You want only the things that are in the National Formulary that should be sold, isn't that right?

Mr. ROOKE. We want the physicians to have free choice of prescribing those drugs he thinks his patients need.

Senator ANDERSON. You do not want the local hospital to say anything about it.

Mr. WALLER. We believe that what you have in your definition of drugs and biologicals, without the approval of the so-called pharmacy and the drug therapeutic committee, is complete in itself. You may decide that you want to elaborate on it, but in itself you are saying that most of these items are already included, so there is no question about drug restriction.

Senator ANDERSON. If it is included, why does it hurt to mention them again?

Mr. WALLER. I am sorry, Mr. Chairman.

Senator ANDERSON. If they are included why does it hurt to mention them again? Don't you trust the therapeutic committee of a small hospital?

Mr. WALLER. The compendia listed in the bill limits and restricts the use of drugs. The basic reason for the therapeutic committee is not to determine whether a drug is good or anything else. They are trying

to restrict a group of drugs that the hospital pharmacist can dispense. This is the point of the therapeutics committee.

Senator ANDERSON. What does the language mean? The first part says the National Formulary, doesn't it?

Mr. WALLER. Yes.

Senator ANDERSON. Or as are approved by the pharmacy and drug therapeutic committee or equivalent committee of the medical staff of the hospital furnishing such drugs and biologicals. So these are extra things that are not in the formulary as long as they are approved there, isn't that right?

Mr. WALLER. Well, in our opinion——

Senator ANDERSON. Will you please answer the question.

Mr. WALLER. I am sorry, I did not hear it.

Senator BENNETT. May I ask a question, Mr. Chairman? Is the purpose of an approved list in a hospital to restrict the variety of more or less identical item which the hospital pharmacy must carry so that it will have a much smaller stock than would be available in a drug store?

Mr. WALLER. That is definitely one of the purposes, yes. In other words, it creates a double standard in the hospitals against a pharmacy which is required to carry a complete, full line.

Senator BENNETT. It seems to me there is an economic factor here. The hospital does not want to carry a complete list, so they restrict the list for the sake of their investment.

Mr. WALLER. Yes, sir.

Senator BENNETT. And to the extent that that is the reason it seems to me it should not be supported by this principle of law. In other words, a physician should not be denied the right to change a particular medicine simply because the hospital decides it does not want to carry that medicine for economic reasons.

Mr. WALLER. That is very well said, Senator.

Senator ANDERSON. I hope you examine it because you just got through saying the opposite of what you believe.

Mr. WALLER. Pardon?

Senator ANDERSON. You believe we should take out that part which gives the drug and therapeutic committee a chance to include the things not carried in the formulary?

Senator BENNETT. It is the other way around.

Mr. WALLER. We are suggesting that you take that language out.

Senator ANDERSON. When you take it out, you therefore put it back to the things in the formulary; isn't that right?

Mr. WALLER. It will be back so that the drugs and biologicals can include anything that the doctor may prescribe. We want the doctor to have complete freedom of choice, and we do not want the hospitals to be in a position, or the institutions to be in a position, to restrict the doctor or the hospital pharmacist for that matter in this particular picture.

Senator ANDERSON. I wish you would read it again some time because some of the doctors think the reverse. This says you can only take those things which are in the formulary or in the pharmacopoeia, and then it says or those that are approved by the pharmacy or the drug therapeutic committee of the medical staff of the hospital.

and you are saying they are not to be allowed to do these things, take the medical staff out, and just things that are in the formulary; isn't that what you are saying in your amendment?

Mr. WALLER. Mr. Chairman, the basic purpose of this language, as I see it——

Senator ANDERSON. Never mind the basic purpose; isn't that what you are saying in this amendment?

Mr. WALLER. Correct; I agree with you.

Senator ANDERSON. All right; thank you.

Mr. WALLER. I am sorry I did not hear all your questions.

Senator ANDERSON. Are there other questions?

Mr. ROOKE. Mr. Chairman, this committee does not comprise the entire staff of the hospital. This committee, which decides how many drugs can be stocked by the dispensary, does not reflect the opinion of all the physicians that visit the hospital.

Senator ANDERSON. Are there additional questions? Thank you very much.

Mr. Harlow.

STATEMENT OF ARTHUR H. HARLOW, JR., PRESIDENT, GROUP HEALTH INSURANCE OF NEW YORK, INC.

Mr. HARLOW. Mr. Chairman and gentlemen, I am president of Group Health Insurance of New York, Inc., known as GHI, the largest independent, nonprofit medical care insurance organization in the United States that offers its subscribers free choice of doctors. We now insure almost 900,000 people and process more than 40,000 claims per week.

We are a consumer-oriented plan. Our bylaws require that no more than half the members of our board of directors may be doctors. We have successfully served for 27 years as a quasi-public intermediary between the buyers and providers of service.

I am pleased to testify in favor of the bill now before your committee. We recognize that private plans have not been able adequately to finance the medical needs of the aged. GHI, over the years, has made a number of special provisions for the aged but these have not been enough. Financial resources of those over 65 are obviously inadequate. Involvement of the Federal Government is essential.

We hope, furthermore, that just as the original social security pension allowances stimulated the development of private pension plans, the bill before you will foster urgently needed, comprehensive medical care insurance in the voluntary area—not only for those over 65.

Naturally, we do not believe that the bill as submitted is perfect, nor for that matter, was perfection probably true of any other legislation that was originally introduced into a new field.

We believe one needed improvement is the inclusion in part A of certain in-hospital specialist services, as recommended by the Secretary of Health, Education, and Welfare. In addition, we regret the exclusion of preventive medicine and the inclusion of coinsurance and such a substantial deductible. The purposes of comprehensive medical care insurance plans has always been to eliminate the financial barrier between the patient and the care he needs. A deductible is just such a barrier.

Most important, however, is our conviction that, if this government program is to function at its highest possible level of usefulness, it should make maximum use of the strengths of the private sector. Competition among private plans has resulted in progress toward control of costs, prevention of overutilization, and prompt effective administration. Medicare should profit from continuing competition.

In section 1842, the bill provides that "the Secretary shall to the extent possible enter into contracts" with "carriers" to administer part B. What may not be clear and what we hope your committee report will clarify as a matter of legislative intent, without necessarily amending the bill, is that the Secretary should deal where possible with more than one carrier in a given geographic area.

There would be many advantages to competition between carriers in an area. First, yardsticks of the cost of administering benefits can be created. For example, judging by reports filed with the New York State Department of Insurance, it costs GHI about half what it costs its local nonprofit competitor to process a claim.

Second, by using experienced carriers, existing procedures for the control of overcharging and overutilization would be included in the Federal program.

To illustrate, GHI uses electronic machinery to check on the number of services for which payment should be made according to standards established for each diagnosis. Specialist consultations are arranged in questionable cases.

Most important, more than 10,000 doctors have agreed to limit their fees to the moderate amounts paid by GHI. Such existing arrangements will limit fee levels more effectively than will the mere phrases "reasonable costs" or "reasonable charges" now in the bill. Consumer-oriented organizations have historically been the most vigorous and effective in developing techniques to maintain control of costs.

That competition among carriers is administratively practical is proven by the large number of such programs already in effect. A list of some of the larger choice programs in which GHI participates is attached. More than 750,000 people in the New York area are included. Of greatest interest to the committee, perhaps, is the inclusion on that list of the Federal employee program, as well as those of State and city employees. So far as we know, in every case where choice has been offered, it has worked out to the satisfaction of all concerned.

GHI is only one plan and New York is only one area where competition between established, substantial, and experienced agencies is possible. We hope that your committee will recommend that, wherever it can be done, these independent plans be incorporated into the program. Administration of part B should not be turned over completely to representatives of the profferers of services, like Blue Shield, or to the commercial insurance industry. The independent, nonprofit plans will bring to medicare the beneficial results of private competition.

(The attached follows:)

GROUP HEALTH INSURANCE, INC.—LIST OF LARGER GROUPS WITH CHOICE PROGRAMS

Federal employees.
New York State employees.
New York City employees.
New York Post.
Helena Rubenstein, Inc.
The American News Co., Inc.
Taxi industry.
I.A.M., district 15 welfare fund (Machinists Union).
Painting industry insurance fund.
Milk industry welfare fund.
Ice cream industry welfare fund.
Brewers Board of Trade, Brewery Workers welfare fund.
Actors Equity insurance fund.
New York Paper Cutters Union.
Iron Workers welfare pension fund.
Office Employees International Union, Local 153 welfare fund.

Senator ANDERSON. Thank you, Mr. Harlow.

Were you here earlier when we were talking about the experience of insurance companies when Mr. Eddy was on the stand?

Mr. HARLOW. Yes, sir.

Senator ANDERSON. I do not think you have time to do it now, but is there any possibility that you might take a look at part B and give us your estimate as to whether or not the premiums to be provided are adequate for the service to be rendered or is that outside your field of activity?

Mr. HARLOW. No, sir; I think I can speak from a good deal of experience. The benefits of our plan cover an unlimited number of doctors' visits to the home, as well as patients' visits to the doctor. There is one variable in this bill that is pretty hard to predict, and that is the level of fees. Our plan pays $4 for an office visit and $6 for a visit to the home. If those are the fees to be paid, $6 per month is plenty. If, however, the fees that are payable under this bill go up substantially, then there may be some question as to whether the $6 is enough or not. But if the fees remain at anything like this level on the basis of our experience, the hundreds of thousands of people paying for an unlimited number of home and office calls and ambulatory diagnostic visits, the $6 is adequate.

Senator ANDERSON. Thank you.

Any subsequent ideas you have on that we would be very happy to have because you are serving a great many people, and I understand serving them very well, and I would be happy to have anything if you have any information on it.

Mr. HARLOW. I would be glad to send you our experience on it.

Senator ANDERSON. It would be very useful, I think, to have.

Senator CURTIS. May I ask one question?

Are most of the people that you insure employees?

Mr. HARLOW. Yes, sir; we only enroll employed groups. When people leave those groups they can maintain their insurance on an individual basis, and we have many thousands of retirees who have left employment.

Senator CURTIS. That is all.

Senator ANDERSON. You mentioned the fact of competition. Do you compete for these groups you now have covered like American News, taxi industry, machinists, and so forth?

Mr. HARLOW. All those groups that are listed there, sir; each individual member of the group has a choice of carriers. The two most recent in New York, the taxi industry, where we competed against the health insurance plan and Blue Shield, and we got the most of the three, then the city employees of the city of New York, where we got twice as many as Blue Shield.

Senator ANDERSON. Now then, when this group was up for bidding, did HIP submit a bid and did you submit a bid also?

Mr. HARLOW. We all offered—they have a choice of three plans as described in centrally designed literature. They can buy HIP, Blue Shield, or GHI coverage. Of the individual members of the last two groups we have gotten substantial majorities.

Senator ANDERSON. And you are suggesting wherever it is possible to get competition and bidding for this service there should be competition?

Mr. HARLOW. Absolutely. These groups should be open to choice. As a rule, choices are opened again for group members every year or a year and a half and the fact that the insurance carriers are on the spot, I think tends to make them peform more effectively.

Senator ANDERSON. I am not trying to commit the committee on this, but would you mind sending down to me the bidding on these two contracts that you mentioned where you and HIP and Blue Shield competed?

Mr. HARLOW. Certainly, sir.

Senator ANDERSON. I would appreciate it.

Mr. HARLOW. Very glad to.

(The following letter was subsequently submitted for the record. The attachments referred to in the letter were too voluminous for inclusion in the printed record and were made a part of the committee files.)

GROUP HEALTH INSURANCE,
New York, N.Y., May 14, 1965.

Mrs. ELIZABETH B. SPRINGER,
Chief Clerk, Senate Committee on Finance,
New Senate Office Building,
Washington, D.C.

DEAR MRS. SPRINGER: This letter, and the material attached hereto, is forwarded in response to specific requests made by Senator Anderson during the testimony of Arthur H. Harlow, Jr., president of Group Health Insurance of New York, before your committee on the matter of H.R. 6675. It is being forwarded by me at Mr. Harlow's request, because of his current absence due to illness.

Two specific areas of information are covered:

(1) Examples of the kind of materials issued to eligible subscribers enrolling in choice-of-plan arrangements, said materials being those issued to employees of New York's taxi industry and to certain employees of the city of New York. It is expected that the city group will shortly include all of its 290,000 employees.

(2) Based on experience under our comprehensive plans, an indication of why we feel that the estimated $6 a month cost, for part B of the program, is actuarily sound.

With respect to (1) above, the attached packet of materials include the covering instructions and descriptive brochures which were distributed to members of New York City employee group.

Also included is the GHI brochure used in the taxi industry situation. The descriptive materials issued in that case by the other participating medical plans followed the same general format.

In both of the choice situations mentioned in Mr. Harlow's testimony, and referred to in the material enclosed, GHI's program was chosen by a greater number of enrollees than the plan offered by the local Blue Shield organization.

We feel that with appropriate adjustment, this choice-of-plan technique would be administratively applicable to the part B section of the medicare program.

With respect to item (2) covering the cost question, the following is submitted:

The highest cash claims level of any of GHI's retiree groups produced an utilization level of $77 per annum per capita, which approximates twice the level of use for our typical employed group utilization.

In order to make the most conservative estimate, we assume that the medicare program part B utilization level would be approximately 2½ times that of our active group, or approximately $100 per annum per capita.

We estimate that the cost of those benefits again be most conservative, which are included in part B, but which are not ordinarily part of our medical program (hospital costs for psychiatric care, home-care benefits, and benefits for certain prosthetic appliances) to be an additional $15 per annum per capita.

From this total cash claim cost of $115 we deduct $35 (rather than the full $50) which represents our estimate of the claims cost saving resulting from the part B deductible provided in the bill.

The remaining $80 per annum per capita cost, which is the product of an initially conservative estimate as to the value of benefits and a conservative application of the deductible, can be further reduced as a result of the 20 percent coinsurance feature, leaving a net cash claim cost per annum of $64 per capita.

Allowing for a 10-percent charge for administrative costs, the result is a $70.40 per annum cost or $5.87 per capita monthly.

As you can see from the foregoing, assuming that doctor services are rendered at the schedule of fees outlined in the attached GHI brochures, the $6 per month cost estimate is sound.

Let me extend, for Mr. Harlow and our organization, our appreciation for the courtesy shown during his appearance at your hearing. If we can be of any further service or provide any additional information, we are at your disposal.

Sincerely,

JOHN C. MCCABE.

Senator ANDERSON. Senator Douglas?

Senator DOUGLAS. I was much interested and greatly pleased by your endorsement of the recommendation of Secretary Celebrezze and others that the costs of the hospital services of medical specialists, the pathologists, X-ray men, physical medicine services, doctors, and anesthetists, be covered under the basic hospitalization plan where the hospital normally includes these costs in its bill.

Some weeks before Secretary Celebrezze testified, some of us introduced an amendment to provide for this, and I would appreciate if you would look it over and see whether it meets your approval.

Senator ANDERSON. You know what is in the Douglas amendment, do you not?

Mr. HARLOW. Yes.

Senator ANDERSON. It restores the original King-Anderson language.

Mr. HARLOW. I think it is a fine amendment.

Senator DOUGLAS. You approve it?

Mr. HARLOW. Yes.

Senator DOUGLAS. I notice that one of your patrons is Helena Rubenstein, Inc. This is an organization which is highly conscious of beauty and health, is it not?

Mr. HARLOW. I should imagine so.

Senator DOUGLAS. And the employees of that organization sell beauty and health to the women of the world, isn't that true, sir?

Mr. HARLOW. Yes.

Senator DOUGLAS. It sells them to the affluent women of the world.

Mr. HARLOW. Yes. sir.

Senator DOUGLAS. What proportion of the employees of Helena Rubenstein subscribe to your group health insurance plan?

Mr. HARLOW. A rough guess, somewhere between 85 and 90.

Senator DOUGLAS. So that they, having looked the field over, put their bets on Group Health, is that right?

Mr. HARLOW. It is a nice way to say it, sir; yes.

Senator DOUGLAS. I think it is a very eloquent tribute to you.

Did you hear the testimony of the very fine gentleman from Richmond representing the American Retail Druggists Association, sir?

Mr. HARLOW. Yes, sir.

Senator DOUGLAS. In his supplementary statement, he wanted to have brand names prescribed by physicians more or less mandated into the drug section of the bill?

Mr. HARLOW. Yes, sir.

Senator DOUGLAS. Do you deal with hospital insurance or just medical and surgical?

Mr. HARLOW. Currently just for doctors, not with hospitals.

Senator DOUGLAS. Would you care to express yourself on this question, or do you regard it as outside your field of competence, sir?

Mr. HARLOW. Yes; we have no direct experience with this problem.

Senator DOUGLAS. Thank you very much.

Senator ANDERSON. Thank you very much, Mr. Harlow. We shall expect to hear from you some more.

Mr. Cullen?

STATEMENT OF GEORGE L. CULLEN, CHAIRMAN, HOSPITAL TASK FORCE, COMMERCE AND INDUSTRY COUNCIL, GREATER PHILADELPHIA CHAMBER OF COMMERCE, PHILADELPHIA, PA.

Mr. CULLEN. I am George L. Cullen, superintendent of personnel administration of the Strawbridge & Clothier, a complete department store organization of approximately 6,000 employees in 7 locations. It is as chairman of the hospital task force of the Greater Philadelphia Chamber of Commerce that I am speaking this morning.

Organized 7 years ago because of alarm over the rising costs of medical care in the great Delaware Valley of Pennsylvania, the task force during recent years has periodically called combined meetings with the top officers of the Philadelphia County Medical Society, the Philadelphia County Osteopathic Society, Blue Cross of Greater Philadelphia, the Delaware Valley Hospital Council, and the Hospital Survey Committee. Through its task force the chamber has urged and supported various recommendations, including hospital utilization committees and long-term nursing institutions, to help assure good medical care at reasonable cost. The work of the task force was represented last November in the printing and distribution of 14,000 copies of a 16-page booklet (copy attached) outlining steps which physicians and hospitals could each specifically take to help achieve adequate medical care at reasonable cost. The booklet has received national recognition. We believe we have an informed opinion on the subject matter of H.R. 6675.

(The booklet referred to follows:)

HOW YOU CAN HELP HOLD DOWN THE RISING COSTS OF HOSPITAL CARE

A Personal Appeal From the Greater Philadelphia Chamber of Commerce Hospital Task Force

INDEX

HOSPITAL TASK FORCE OF THE CHAMBER OF COMMERCE OF GREATER PHILADELPHIA

Chairman, George L. Cullen, superintendent of personnel administration, Strawbridge & Clothier.
Arthur R. Boyd, personuel manager, E. F. Houghton & Co.
Frank R. Cadman, director of personnel, Temple University Medical Center.
George E. Deming, Jr., personnel manager, Methodist Hospital.
George C. Foust, vice president, Towers, Perrin, Forster & Crosby, Inc.
Edward M. Morgan, Jr., manager, insurance department, Rohm & Haas, Inc.
Walter P. Paul, Jr., director of industrial relations, Philadelphia Gas Works Division, UGI Co.
Robert B. Rogers,, manager, health and safety, SKF Industries, Inc.
Calvin R. Stafford, director of industrial relations, the Masland Duraleather Co.
Gustave L. Vogt, senior research assistant, Atlantic Refining Co.

The Problem

The business community of Metropolitan Philadelphia has long taken a just pride in its hospital system in which more than $1 billion has been invested. It supports the hospitals, serves on their boards, helps raise funds, and sponsors insurance programs for employees to make immense resources available for patient care. Without such help many of our institutions would have ceased to function.

While this interest is fundamentally humanitarian it has not been entirely without other motive. The preservation of the best medical care in the world is basic to our way of life. Continuing it in an age when, increasingly, strident voices are heard urging Government intervention, is a responsibility resting heavily on the hospital trustee, the administrator, the doctor, as well as on all of us who can offer active encouragement to voluntary methods.

Success can only be achieved when the highest quality of hospital care is provided at the lowest possible cost.

Notable efforts by hospitals, doctors

Hospitals here are engaged in a variety of important efforts to make their dollars go further. Working through the Delaware Valley Hospital Council they have set up central agencies for purchasing and bad-debt collection. Many have developed progressive or intensive care units, concentrating personnel in the most urgent patient areas. Some are engaged in training programs to help supervisory personnel make more effective use of unskilled employees, who constitute the bulk of a hospital's corps of labor as well as its wage outlay. At the same time, our local and State medical and osteopathic societies have put their shoulders against the rising cost wheel, cooperating with hospitals and insurers in seeking and implementing ways to gain the most value from the medical care dollar. Officers of the societies have urged the profession to set up hospital utilization committees and to adopt other promising measures aimed at promoting wisest use of health services.

** * * Still, costs continue to soar*

Yet in spite of all that has been done hospital costs continue to rise. So does the use—probably some overuse and injudicious use—of hospitals. And, consequently, so does the cost of hospital insurance since rates reflect increases in hospital costs as well as extent of use of services by policyholders or subscribers.

The hospital task force of the Chamber of Commerce of Greater Philadelphia—composed principally of leaders from business, working with representatives from the hospital and medical community—has been studying the problem for 6 years. They fully appreciate the two basic reasons why hospital care today must cost more than it did a decade or even 5 years ago.

They recognize that (1) higher costs must attend technical advances in medicine and surgery; (2) hospital people should receive decent wages. We can't turn back the clock here—nor would we wish to.

But additional factors generally viewed as contributing to the growing bulge of the patient's hospital bill can and should be managed. Briefly these are—

(3) Unnecessary hospital admissions; (4) faulty, inefficient use of hospital services or days of stay due to poor scheduling or weak handling of the patient case because of adherence to outmoded "system."

(5) Ineffective employment and deployment of the hospital's army of unskilled help. Too often this is responsible for the rising ratio of personnel to beds. ("Let's hire a half dozen more" is not always the answer: "Let's better train and use the people we have" makes more sense in cutting down expensive turnover.) (6) Unnecessary hospital construction and interinstitutional rivalry that results in duplication of services in the community.

A time for new concepts

The chamber's hospital task force has been impressed by the wealth of new ideas abroad in the hospital field today indicating that leaders are alive to the costly effect of the above-mentioned factors and are trying to take all practical measures to control them. These leaders are developing new concepts of handling patients. They are introducing interesting practices and administrative innovations, all calculated to conserve community health dollars. They are lending ear to helpful suggestions made by authorities who devote all their time to the complexities of rising hospital costs.

True, some of the programs are hardly above the experimental level. But many others have been amply field tested by now and hold great promise of whittling away at one edge or another of rising costs.

The purpose of this booklet

This booklet has been produced in the interest of the community, and particularly the business community. It offers a brief résumé of some significant cost-control programs developed here by individual hospitals and their doctors with the active support of the Delaware Valley Hospital Council, Philadelphia County, and suburban county medical societies, Philadelphia County Osteopathic Society, Hospital Survey Committee, Blue Cross, and Health Insurance Council.

All of these programs can be achieved without detracting from the quality of hospital care provided—in fact they should improve it.

Can any of these measures be applied effectively at your hospital to help slow down increases in costs or eliminate unnecessary use of services? We're not certain. We're only certain that the problem is a very serious one and none of us can afford to ignore any ideas or possibilities that can help stabilize the costs of hospital care.

HOSPITAL UTILIZATION (OR BED-USE) COMMITTEES

A bed-use committee is an official group of doctors from the medical staff of each hospital who check to assure that each day of care in the hospital is medically significant to the patient. They see to it that delays in needed services, procedures, and final discharge are avoided.

The introduction and success of this program rests almost entirely on a hospital's medical staff. Its committee may be composed of up to a dozen doctors who work along with administrative representation. Gaining medical interest and understanding usually grows out of informative meetings of physicians and hospital administrators that lead to an appreciation of this fundamental question: "What is the best way to give every patient in the hospital all the care he needs while avoiding unnecessary admissions and unneeded days of stay?"

What a bed-use committee does

Though the actual system may vary among hospitals that adopt the bed-use committee device, this basic course is followed under the committee's continuous supervision:

1. All admissions are subject to review from the standpoint that no patient should be in the hospital on any day not medically necessary. If his case could

be handled properly on an out-patient basis, in a doctor's office or in a hospital, his dollars (including those he pays for insurance) should not be wasted on needless occupancy of an expensive facility.

2. At admission, each case is evaluated as to type to see if it is an emergency, urgent, or elective. Priority is assigned accordingly. This means the hospital's beds will be occupied first by those whose need is greatest.

3. When a patient ceases to be an "acute case" he should leave his hospital bed for a less costly, nonacute facility, such as an approved nursing home, a home for the aged, or his own home—perhaps under the hospital's formal home-care program if his condition requires it.

Medical teamwork can be effective

Here's how the utilization committee operates. First, it scrutinizes all admissions to make sure they are warranted. Thereafter, at some hospitals, reviewing teams of doctors, assigned on a rotating basis, make a daily check of patient medical records to ascertain whether services are being promptly rendered and wisely used and that stays are not needlessly prolonged. These physicians may question a case and make recommendations. If the doctor in charge of the case disagrees, provisions are available for review with members of the utilization committee.

State and local medical and osteopathic societies have officially endorsed the desirability of establishing a bed-use committee as an integral part of each medical staff at all hospitals. Here the Philadelphia County Medical Society has applied itself diligently to the creation of such committees in every hospital. The Honorable Arlin M. Adams, Pennsylvania's secretary of public welfare, acting for the Governor's hospital study commission, has urged that such programs be quickly adopted.

Hospitals where such committees have been set up report varying degrees of success in holding the cost line and eliminating wasteful practices.

Medical society committee will assist

If your hospital has not yet introduced this promising program you should give it your most careful consideration at this time. Dr. William Gash, chairman of the Philadelphia County Medical Society's Hospital Utilization Committee has been holding periodic meetings with physician representatives of utilization committees throughout the area and would be glad to explain how such a committee could be established at your hospital. Dr. Gash can be reached through the Philadelphia County Medical Society.

PREADMISSION TESTING (WORKUPS BEFORE ADMISSION)

Ordinarily, doctors order a number of tests for their patients before hospital treatment or surgery is undertaken; X-ray, blood chemistry, urinalysis, electrocardiogram, et cetera. Scheduling and performing these studies are often quite time consuming.

Tests do not begin customarily until after the patient has been admitted to the hospital. Thus the patient may occupy a bed for several days, leaving his room only now and then for a test until diagnosis is completed. For each of these days, hospitals in Greater Philadelphia charge an average of $41.16. There is evidence that needless bed occupancy is contributing substantially to the cost of the average hospital case.

Outpatient tests lower costs

While it is true that some required tests must be performed under controlled conditions, it is equally true that many examinations can just as accurately be made at the hospital on an outpatient basis a day or two before actual admission. This eliminates useless, costly bed occupancy and unnecessarily prolonged stays and generally works to the convenience and financial advantage of the patient.

Some thoughtful hospitals here have already introduced a program that, as a matter of course, calls for preadmission testing of patients whenever practical. To cooperate, Blue Cross and private insurance companies make special arrangements to cover pretests on the same basis as after hospital admission.

As was indicated in stating the problem at the beginning of this booklet, one prime factor contributing to rising hospital costs (by prolonging stays unnecessarily) are some wasteful days of patient care due to defects in the hospital's system, or general routine. This includes, for instance, faulty scheduling of diagnostic tests and examinations and delays in their performance. Pre-

admission test automatically guarantees that this kind of delay won't extend a patient's stay since the tests were already completed before the stay began.

Pretesting holds promise

The Evening Bulletin, editorially has called preadmission testing the "potential key to solving a problem for which Philadelphia is justly infamous." It referred to the fact that the average length of a hospital stay here is one of the highest for any metropolitan area in the country.

There is every hope that the general practice of preadmission testing can cut average length of hospital stay in our community to considerable degree and bring it in more favorable comparison with other metropolitan areas. Is your hospital looking into the possibilities of this program?

THE 7-DAY HOSPITAL WEEK

Except in the handling of emergency cases, many hospitals on Saturday and Sunday all but close down important departments—such as operating rooms and those providing X-ray, laboratory examinations, and other vital anicillary services. What amounts to a 5-day week is the general rule.

Unfortunately, as some authorities are now pointing out, this practice does not provide the most efficient use of the most expensive part of a hospital's facilities. Many patients are admitted to the hospital, on the order of their doctors, on Friday or Saturday, even though the necessary tests they require are not generally available until some time on Monday morning.

Not just your chamber of commerce's hospital task force by those closer to hospital and health economics have become increasingly concerned about this costly situation with hospital charges already averaging over $41 a day and continuing to rise.

Six-and seven-day week spreading

Eight hospitals here now operate regularly on a 6-day basis. Another has found that by changing from a 5-day week to a 6-day and finally to a 7-day week, it has not only saved money for patients but gained income for the hospital as well. It even schedules weekend surgery. No longer does valuable equipment, costing many thousands of dollars, lie idle for 2 days every week. No longer are there Monday morning jam ups in the operating rooms, laboratory and X-ray departments. No longer are the patients remaining in bed over the weekend waiting for Monday's action.

What's more, this hospital has not only leveled off "the peaks and valleys" of its services but it makes better use of its personnel and has avoided the need for adding additional help in the expensive, turnover merry-go-round described earlier, a leading factor in rising hospital costs. Just as important, it circumvented a need to construct new facilities, now unnecessary. Last year it increased its operating budget by $500,000 at no increase in patient charges.

Additional benefits of longer workweek

Hospitals suffering a chronic "waiting list" problem should find extension of their active working week especially beneficial. So would the cause of wise bed use, since too often the 5-day week in such institutions results in "bed grabbing." A doctor may call his patient on a Friday to say, "I know you didn't expect to enter the hospital until next Monday, which ordinarily would be better, but I can get a bed for you this Saturday or Sunday and suggest you take it—otherwise you run the chance of not being admitted for another week or two." Thus arises another case of the costly and useless "lost weekend" in the hospital.

The 7-day program appears to be particularly applicable to hospitals with over 200 beds, for in these the employee workweek can be "staggered." While it is not difficult to convince doctors of the efficiency of the 7-day week, good communication with the employees is essential in developing such a program. In the hospital referred to, employees continued to work an average 40-hour week, received a moderate increase in wages, and were guaranteed a stretch of 4 continuous days off each month.

Advanced thinking is essential

Doesn't this seem the type of programing that can help reduce costs and heighten efficiency, improve the quantity and quality of medical care, and lower the average length of patient stay in almost every fairly large hospital here—perhaps yours? The business community is counting on your support and encouragement of each and every progressive measure that will lower hospital costs for the patient and tend to preserve the freedom of hopitals and medicine.

HOSPITAL SERVICES IN THE HOME

Some large hospitals in Greater Philadelphia have started pilot programs that make better use of their facilities (thus avoiding unneeded construction) by this device:

When it is determined that a patient no longer benefits appreciably by occupying a hospital bed—although he still may require some hospital-type services—he is discharged. Then, hospital and nursing services follow him into his own home. Under this program, where home care is applicable, Blue Cross continues to provide benefits as the patient leaves the hospital for this less expensive service.

The cost of at-home care, no matter who is paying for it, is bound to be approximately one-quarter or even less of that for inhospital care.

The patient benefits, too

What's more, there are other advantges of this program from the patient's point of view. The relaxed, less regimented and familiar environment of his own home often hastens recovery. Prolonged hospitalization is disturbing not only to the patient but also to his family which is usually relieved to have their loved one back home where they can contribute personally to his recovery. They are encouraged, also, by the assurance that needed hospital services are available in the home along with immediate readmission to the hospital if necessary.

Decision for the transfer from hospital to home, of course, rests on the attending physician, along with the hospital program's coordinator. As for nursing service, it can be provided by either the hospital or a visiting nurse association.

As required, the hospital can arrange to deliver a hospital bed, wheelchair, oxygen tent, physical therapy tub, fracture equipment, prescribed medication, crutches, et cetera, to the home, and even transport a portable X-ray machine or electrocardiogram equipment, along with the personnel to operate them.

What we have said up to this point

All that is needed in many hospitals to bring to reality such challenging, novel techniques as we are describing is a recognition that money savings of all types must be made for the patient or the cost of modern hospital care—whether out of pocket or through insurance premiums—is surely going to soar beyond his reach.

Some people see socialized medicine as the only solution. Yet it need not be, if voluntary hospital administration, the trustees, and medical staff will pool their ingenuity and work together with the encouragement of their community, to promote efficiency, effect economies and adopt practical ideas that will—without sacrificing the best of patient care—see to it that hospital dollars are always spent most wisely.

TRANSFER TO A CONVALESCENT FACILITY

What to do with patients who aren't ill enough to occupy today's costly hospital accommodations while there is every indication that the minimum, routine care they require—meals, attendance, varying degrees of bed rest, medication, occasional tests—could easily and beneficially be provided in a less costly accommodation?

This type of convalescent, usually of older years, is familiar to every hospital administrator. The institution can do little more for him. In effect, and through no fault of his own, he is misusing hospital services. He, or she—and their number is legion—is adding to the community's cost of hospitalization. Somebody is carrying this patient financially: himself (probably unlikely) or relatives; Blue Cross or insurance companies, or the State or the hospital itself.

This type of patient belongs in a convalescent or nursing home where the cost of care—perhaps $12 per day—is approximately one-third that of general hospital care. Yet the hospital's social worker finds that some homes won't take him if he can walk about, even though it helps his recovery. Complicating the picture, probably he and his family are not familiar with the availability of alternate facilities.

What some hospitals are doing

Isn't the challenge of such problem patients worthy of management's best abilities? One hospital here has a contractual affiliation with a convalescent home. There is every indication that such facilities, directly connected with various hospitals, will multiply conspicuously in the next year or two. Meanwhile, numerous hospitals are now considering formal affiliation with some of the region's 83 licensed convalescent homes.

Still other hospitals are coming to recognize—and this may answer a number of rising cost problems—that one or two of its wings where beds are idle (perhaps maternity or pediatric beds) can now be converted to less expensive facilities devoted to convalescent care. This is all a part of progressive care treatment, moving a patient along according to his requirements.

Nursing beds in short supply

There is no doubt that our area now has too few convalescent beds in relation to hospital beds. Or in relation to our population, for which the convalescent need is rapidly growing, These facts are frequently commented upon by competent visitors from other areas and verified by the hospital survey committee. Yet it costs only around $5,000 to $7,000 to bring a nursing home bed into existence as compared with about $30,000 for a hospital bed.

Perhaps your hospital will be among the first to find a workable day-to-day solution to the facility-transfer problem. Potentially, this could be among the most practical means of retarding the danger-laden march of rising hospital costs.

THE USE-ANALYSIS PROGRAM

Working with hospitals/doctors, on the one hand, and management/labor on the other, Blue Cross here has introduced a unique program calculated to help curb the rising costs of hospitalization and hospital insurance.

Routinely, Blue Cross staff reviewers always have carefully examined the hospital bills submitted for each subscriber-patient, checking the services used. Where questions arise the cases are turned over to the physicians' review board or dental review board, composed of prominent practicing doctors. If such action is warranted they may disapprove payment of the bill.

Now, going one step further, for companies and unions that have asked to participate in a new plan, Blue Cross makes a special study in representative samples of their hospital cases to see what happened, medically, day by day, during the admissions to determine whether an admission could have been handled in fewer days—or was even necessary at all.

Report to management

Questionable cases are brought to the attention of the utilization committee or medical staff officers at the hospital involved. A general report finally is made to the interested company or union.

In brief, the program consists of immediate notification of company or union by Blue Cross when one of their group is hospitalized; completion of a "utilization report form" by the patient after discharge regarding promptness and efficiency of service during his stay; analysis of these reports by a Blue Cross doctor, and then consultation at the hospital if overuse or inefficient use of Blue Cross benefits is found.

The utilization report is filed by the patient, after discharge, with his employer or union. All reports are turned over to Blue Cross. When a case is in question, a Blue Cross registered nurse visits the hospital and brings back a copy of the patient's medical record for a Blue Cross physician's detailed study.

The search for costly delays

What Blue Cross is looking for, particularly, is whether a hospital stay was abnormally long for a particular diagnosis and what brought this about. It is interested in cases where there were unnecessary delays such as an undue time lag in ordering or actually performing tests and treatments; or in scheduling and performing surgery. Finally, Blue Cross wants to know whether there was unnecessary delay in discharging the patient once he was well enough to leave.

Such practices, of course, can lengthen the patient's hospital stay and swell the cost of his hospital care.

After a sufficient number of analyzed cases are accumulated to indicate a pattern for an individual hospital, Dr. William Benson Harer, Director of Medical Affairs for Blue Cross, writes to the doctor who is chairman of the hospital's "utilization committee"—if one has been established; otherwise, to the chief of the medical staff. Dr. Harer requests an appointment to discuss the case findings with representatives of the hospital's medical staff and administration. A list of cases is sent to the hospital in advance for its examination.

Working for improved paterns

Under this program, Blue Cross merely uses a case as a vehicle for getting at the pattern of delays in that particular institution; to demonstrate how a Blue

Cross patient could possibly have gone home a day or two sooner—and money saved.[1]

Constructive discussions center on how delays can be avoided in the future. Medical staff members frequently have useful suggestions for improvement which it would be difficult for "outsiders" to make.

Although the program has been in operation only a short time it already applies to some 160,000 working people and their dependents associated with 175 company or union groups here. Since management and labor have negotiated to pay the costs of hospital insurance—no small bill today—they want increasing assurance that their moneys are wisely spent and all doubtful factors looked into that tend to swell costs.

If you are a trustee and businessman, perhaps you may want to get in touch with your Blue Cross or insurance representative and learn how your company may participate in the program. Private insurance companies are also actively participating in utilization control. If you are a doctor or hospital administrator, won't these programs aid you substantially in improving patient care?

COMMUNITY PLANNING IN HOSPITAL CONSTRUCTION

Those in a position to know tell us that probably the leading controllable factor in hospital costs today is the overproduction of hospital beds and duplication of facilities in a community. Every 100 hospital beds created here adds approximately $1 million a year to the community's cost of maintaining hospital facilities.

A superabundance of unneeded beds in a hospital spells low occupancy—the bugaboo of hospital financing. It requires about $10,000 a year to maintain an unused bed.

There is a general suspicion, too, that when an institution chronically has a number of unoccupied beds the temptation is there to occupy them with patients who might just as properly be cared for in other ways. Again, hospitalization may be prolonged unduly.

To meet the problem, committees or "authorities" have been set up in most of our metropolitan areas. Their function is to endorse or decline endorsement of all new hospital construction. Their aim: to put hospitals on a logical, regional planning basis.

The planning agency for our area

Here, the hospital survey committee, supported by voluntary contributions from 80 corporations, foundations, and interested agencies, was formed in 1960 as the advisory planning agency.

Some believe only a governmental arm can stop excess building. The approach here might be described as one of gentle persuasion. Considerable progress has been made. But it is only a start.

In its 1964 report, the committee states flatly that the community has not yet made best use of its hospital facilities and, as a result, the cost of hospital care is higher than it should be. The committee tells us that the average occupancy rates of the area's hospitals are still too low (unnecessary beds) and the average length of stay still too long.

The committee believes progress made to date demonstrates that, if individual hospitals are given the facts and voluntarily determine their future programs on these facts, they will build wisely for the good of the community as a whole.

What has been—and can be—accomplished

Millions of dollars are being saved here already for the public by hospitals voluntarily reshaping their individual capital programs in light of overall area needs as well as the capital plans of other hospitals.

Some 2,400 beds have been withdrawn or postponed from plans which would have involved an estimated construction cost of $60 million and added an additional $24 million to the annual cost of the community to operate its hospitals.

Savings of additional millions of dollars likewise have resulted by hospital consolidations, mergers, and cooperative agreements in recent years.

Of course, some new hospital construction and reconstruction is necessary. Moreover, pride in hospital is an admirable and blessed trait in every individual associated with the institution. But we do not need a hospital at every other street corner nor a $50,000 machine used once a month when there is similar

[1] Blue Cross estimates that if the average length of stay on Blue Cross hospital admissions here were reduced just 1 day it would save the plan and its subscribers about $8 million a year.

equipment at a nearby hospital where a loan or service-swapping arrangement may be made.

Are you in touch with the hospital survey committee's helpful reports and studies? All of us associated with hospitals will do well to follow its findings and suggestions. It is on the right track in assisting us to work toward practical planning of hospital facilities.

IN SUMMARY

In the preceding pages we have listed a number of interesting programs that appear to hold high potential in helping to curb the rising cost of hospital care. They affect the quality of that care only to the extent they would improve it.

We realize there must be many programs, of similar promise, directed at the same goal. But the foregoing make a good start in stimulating the awareness and imagination of all of us who are determined to preserve the freedom of hospitals and medicine in our Nation by preventing the cost of health care from outrunning our ability to pay for it.

Still, we feel we would not be meeting, squarely, the purpose that stimulated publication of this booklet if we did not try to be more specifically helpful. And so, on the back cover, the hospital trustee, the administrator and doctor will find what we hope are definite and useful suggestions.

Mr. CULLEN. Now, this may be surprising, at least to some of our listeners. The Greater Philadelphia Chamber of Commerce, which represents the business leadership of our eight-county, bistate region, is in general sympathy with most of the objectives of H.R. 6675. We approve the extension of Kerr-Mills, we approve the present controls of the basic hospital plan, and we approve of the principle of a separate voluntary, contributory plan with further controls.

However, we make several important observations and vigorously recommend to you several vital amendments to the basic and supplementary plans of health insurance, as follows:

1. Greater emphasis must be placed on the use of medical and insurance experts in drafting the administrative provisions of the bill. Call it by any other name you will, H.R. 6675 is a potentially dangerous step down the road of socialized medicine. If we are not to inflict on our own country the early traumatic experiences of Australia and England, scrupulous care must be taken to design those safeguards and detailed procedures which are mandatory to prevent dilution of the quality of medical care and skyrocketing the cost of medical service to all segments of the population. We endorse, and most sincerely so, the principle of whatever Federal aid is necessary to assure adequate medical service for the medically and aged indigent. We think, however, that such care should be administered at the lowest local level practicable and that existing private institutions, such as Blue Cross, Blue Shield, and the insurance companies should be utilized to administer benefits and provide all services possible under the bill. Although the language of the bill clearly points in this direction, so also should the administration of H.R. 6675 be consistent with our free enterprise system and the important role of the State in our Republic.

2. The provisions on health insurance in H.R. 6675 are so enormous in their implication that more time and study must be given to their implementation. There is not available in this country the present capacity on a proper geographical basis to organize and furnish the nurses, home health aids, therapists, physicians, hospital service, mental beds, and long-term nursing facilities promised by the bill. Such medical capacities, we have confidence, can be developed in the future, but they cannot be properly developed in the few months which

will elapse between the passage of the bill and its presently proposed effective dates. The problem is recognized only in part by the provision of making posthospital extended care available 6 months after the other provisions of the basic and supplementary plans.

3. H.R. 6675 leaves only loosely defined many of the crucial standards and provisions of furnishing medical care, and these must be tightened. The "what" of the bill sounds fine to many people, but how will it actually work, who besides the Secretary of Health, Education, and Welfare and an advisory council will provide the "how," to what outside review and appeal will the "how" be exposed? With what speed can all this be done? We cannot gloss over such fundamental issues as the nature and extent of charges by hospitals and doctors by saying that they shall be "reasonable." Page 31 of the committee report presents, in our opinion, much too peaceful a picture in describing general agreement on the principles of charging. The controversy over what is "reasonable" has been waged hot and heavy for years among hospitals, physicians, insurance companies, and the Blue plans. Will each hospital really be paid its own individual costs, and I quote now from the committee report, "however widely they may vary from one institution to another" as stated on page 32? If so, is not the inefficient hospital being subsidized and the efficient one penalized? Philadelphia area hospital costs vary from $47.54 per patient day to $19.25 per patient day. How much of an allowance in bed cost per day is "reasonable" for depreciation, interest on loans or debt retirement? For example, it is reported that one Philadelphia hospital has a $14 cost per patient day for debt service—although it has no educational programs or indigent care; another hospital with a teaching program and providing indigent care has a debt service cost of less than 50 cents per patient day. With respect to payment of physicians, page 38 of the committee report merely ordains that "reasonable" is the customary charge by each physician and also it shall be the prevailing charge in that community. Reconciling these two different principles in thousands of communities, for thousands of physicians for a thousand medical and surgical procedures will rival the work that went into Coulee Dam.

These questions are not just small details—they go to the very heart of the bill and all interested groups should be allowed time to present expert testimony and carefully resolve problems and differences which are bound to arise. A staff sitting in Washington cannot write the detailed criteria and procedures which are needed to make these provisions workable. There must be adequate study, planning, review, and training on a national and State basis by persons expert in the fields of medical service. The variety of cost allocation systems by each individual hospital would literally stagger the imagination. Uniform medical cost accounting systems and uniform terminology for medical and surgical procedures must be developed and a series of formulas for different types of hospitals be constructed and negotiated or else, we fear, we will need more CPA's and auditors than doctors and nurses to support this new medical bonanza.

4. All possible measures should be provided to help control the cost of medical service which is bound to rise drastically in the future. Neither premium costs nor benefits are graduated according to ability to pay or take into account other private or public funds which may be

available to the claimant. We advocate the serious consideration of these principles to help control costs.

About half of the 19 million people over 65 now have some form of health insurance. What are these people going to do about their private plans now and in the future if the Government will help pick up most of the cost when they are 65? What provision has been made to retain incentive to insure one's own health? Some people will wish to retain their private plan and also take out the Government's supplementary plan. The bill should encourage the retention of plans presently sponsored by employers or carried by individuals.

Premium rates under the supplementary plan can be revised every 2 years. For many obvious reasons, the cost of claims will steadily rise. Here it is surprising to note that with the exception to mental illness, there is no maximum dollar limit imposed on any other item in the basic or supplementary plans. But the avowed purpose of the supplementary plan is to be as nearly self-sufficient financially as possible—the rising cost of claims, of course, should mean higher premiums. However, if a subscriber over 65 cancels his private plan, there will be no turning back for him. He will be bound forever to the Federal plan—and either he, or the Federal Government, or both will have to increase payments every 2 years.

Although it is reported that the actuarial assumptions of H.R. 6675 are conservative and the projection of hospital per diem costs in the future closely parallels an estimate by Blue Cross, we doubt that there will be any leveling off of hospital costs for quite a long time. Parkinson's law that availability determines use will play a very significant role. In short, we strongly suspect that the cost estimates are too low, that premiums will have to rise faster than estimated or that for political purposes Congress will feel obliged to subsidize both plans greatly in excess of what is visualized at this time.

In addition to the rising cost for present benefits, we are greatly concerned about what the next demands will be for extension and improvement in benefits. We fear this will be like the camel's nose in the tent. When will the age limit be dropped to age 62 to match old-age survivors insurance and then to age 60, and what about including everyone who is permanently totally disabled regardless of age? The benefits presently proposed could be only the beginning. This is another of the reasons we urge extreme caution and movement forward slowly—rather than rushing in with giant strides and running the risk of a financial debacle such as confronted our cousins in the British Isles.

In summary, the Greater Philadelphia Chamber of Commerce recommends that H.R. 6675 specifically incorporate the following:

1. The effective date of the basic and supplementary plans should be July 1, 1967.

2. Provision to develop uniform cost accounting systems for hospitals and cost formulas which give proper recognition to major differences among hospitals as to character of services rendered, teaching facilities, and general costs of the area.

3. Reimbursement principles which offer actual financial incentives to hospitals to hold down general costs and to transfer patients to long-term care facilities.

4. Provision for the construction of uniform terminology and numerical coding for all medical and surgical services and procedures.

5. Appropriate review and appeal procedures for items 2, 3, and 4 above by representatives in each State from all important medical, hospital, and insuring associations.

6. Timely notice to and appropriate review and appeal procedures for all interested segments of business and medicine on all other proposed regulations to effectuate the bill.

7. Benefits graduated according to ability to pay and appropriate consideration given to funds available from all other private and public sources.

8. Maximum dollar limits imposed on the supplementary plan.

9. And finally, wording of provisions should prevent all possible abuse by patients and the providers of medical service. The administration should be instructed to withstand in actual practice all the pressures which will be brought to bear by special groups to extend and liberalize benefits.

On behalf of the Greater Philadelphia Chamber of Commerce, I wish to express our appreciation for this opportunity to make known our views on this historic bill.

Thank you.

Senator ANDERSON. Well, thank you. That is a thoughtful statement; we appreciate it.

I notice you refer to the financial troubles they have in the British Isles. There are those who believe that some part of that was due to the fact that the medical profession there resisted too long, and they got socialized medicine, which they did not need to get if they had not fought it so long and, as a matter of fact, if the King-Anderson bill had been passed in 1964, there might not have been so many layers to the cake.

Mr. CULLEN. It may be very true, sir.

Senator ANDERSON. Therefore, I refer to it because of this date of July 1, 1967, which you gave, which might be a little discouraging to a great many people.

Senator Douglas?

Senator DOUGLAS. First, let me say that Mr. Cullen represents a very honorable Philadelphia retail establishment which has a long record of quality merchandise, and I believe, though another Philadelphia company claims the credit, that it was the first big department store in the country to institute a single price system and to abandon the practice of haggling with each purchaser trying to get the maximum price.

Mr. CULLEN. Thank you, sir, for that.

Senator DOUGLAS. I think that is true. And the two families, Strawbridge and Clothier, both Quaker families, have made great contributions to the civic life of Philadelphia.

I notice that you urge delay. Do you think this delay should be in passing the bill or in announcing the administrative regulations subsequent to passing the bill?

Mr. CULLEN. To enable the proper administrative regulations to be formed.

Senator DOUGLAS. That is, you would not be opposed to passing the bill this year?

Mr. CULLEN. No, sir, I would not; provided that proper consideration is given to incorporating some of these matters that we are referring to in our recommendations.

Senator DOUGLAS. Even though it were not completely acceptable down through the crossing of the "t" or the dotting of an "i" and even though it meant considerable flexibility for later administrative determination among the Department of HEW and the hospitals, the doctors, the nonprofit insurers, the profit insurers, and the rest, would you not favor or would you favor holding up the bill?

Mr. CULLEN. No, sir. I think to the contrary; I think that the greater number of months which can elapse between the passage of the bill and the effective date are vital in terms of getting all these various organizations and societies starting to work to iron out the problems. I do not address you this morning in connection with my affiliation with Blue Shield, but I am on the board of directors of Blue Shield of Pennsylvania, and helped form and am chairman of its subscriber advisory council, and I am well aware of the long, difficult negotiations and discussions which have to take place with the medical society, with the Blue Cross plans, and with the hospitals. We just have a great apprehension, as this paper reflects, that the actual mechanics of putting this in are just dreadfully important. The bill offers a lot to our senior citizens. We must not in our haste to crank out administrative provisions provide for sloppy administration which will disappoint them.

Senator DOUGLAS. If I understand the bill correctly, it is to go into effect July 1, 1966. Do you want another year?

Mr. CULLEN. Yes, sir. I believe that year could be put to very good advantage. Your posthospital extended care now recognizes this problem in part by providing for a 6-month delay after the other parts of the program are made effective.

Senator DOUGLAS. You heard the testimony of Mr. Harlow of Group Health of New York. Do you favor competition among insurers or would you favor regional monopolies?

Mr. CULLEN. Well, I think bidding should certainly be competitive on a regional basis.

The definition of region you cannot legislate. I think loosely you will have to take a look at the United States and see what is available. But I think there definitely should be competitive bidding.

I do not believe, and the bill itself recognizes this, that there should be a requirement that the Secretary of Health, Education, and Welfare must necessarily accept the lowest bid. I think he will have to use good judgment, examine the history, the capacity of the competing organizations, consider the competitive prices, and then make a determination.

This obviously could not be done either on the basis of a 1-year contract, let us say. A minimum of 2 or 3 years would be necessary for any organization to whom a bid was awarded.

Senator DOUGLAS. Do you have in Philadelphia an organization comparable to Group Health?

Mr. CULLEN. No, sir; we do not. We have Blue Cross of Philadelphia, we have several, about four Blue Cross plans in our State. In addition we have Blue Shield encompassing all of Pennsylvania and of course, we have, representing the private insurance companies, the Health Insurance Council.

Senator DOUGLAS. Have you taken any position on this question of what drugs may be compensated for?

Mr. CULLEN. No, sir. I think it would be presumptuous for us to venture an opinion. The only thing I would say with respect to that question and with respect to other questions which have been brought up before your committee, such as separation of radiologists, pathologists, and so forth, is that legislation, in itself, should not seek to change relationships among physicians, hospitals, and other segments of the economy that are involved here. I think we should accept conditions as they are, let them naturally evolve, and that we should be guided accordingly in terms of our legislation. I do not make that comment with respect to cost implications. Here I think we must be extremely sensitive.

Senator DOUGLAS. Thank you very much.

Senator ANDERSON. Senator Bennett?

Senator BENNETT. The gentleman from New York, Mr. Harlow, was very proud of the fact that he could underbid all of you, and apparently, as I heard him present his case, this is based on the fact that he puts a limit on the fees that will be paid physicians and, presumably, will not pay a claim unless it represents a visit by one of their authorized physicians. So here we have controlled medical practice.

Blue Cross puts no such limit on the services of physicians who serve its patients, does it?

Mr. CULLEN. Well, Blue Cross is only an agent for payment of physicians. Blue Cross is the agent——

Senator BENNETT. Is the hospital?

Mr. CULLEN. Blue Shield, however, does put a dollar limit on each and every surgical and medical procedure. You have two different concepts. You have the full-service concept being sold by Blue Cross for hospital and hospital services, and you have the fixed-fee schedule being offered by Blue Shield, and some of the insurance companies. The insurance companies themselves, I think, are split on this practice. Some will say reasonable costs; some will say follow the schedule.

Senator BENNETT. Well, the bill says "reasonable costs." So when you say in your summary, recommendation No. 8, maximum dollar limits imposed on the supplementary plan, are you talking about fixed fees imposed on the services of physicians?

Mr. CULLEN. Yes, sir; we do.

Senator BENNETT. Thank you.

Mr. CULLEN. We think that is an important cost consideration.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. With reference to your seventh recommendation, benefits graduated according to your ability to pay, appropriate consideration given to funds available from all other public and private sources, that relates to the benefits. How about the premiums? Are you favoring the payment, for instance, of one-half of this premium for the supplemental benefits out of the Public Treasury for all people, including those able to pay it themselves?

Mr. CULLEN. My comment here, sir, goes more to the point of the basic plan. In other words, I think there should be some kind of means test considered by the legislation.

Senator CURTIS. That would be——

Mr. CULLEN. Obviously, you could not, under the supplementary plan, charge the same premium, but give different benefits.

Senator CURTIS. In other words, you do not favor a Government plan providing hospital and medical benefits for that portion of people over 65 well able to provide it for themselves?

Mr. CULLEN. No, sir; I do not.

Senator CURTIS. I think there is the greatest weakness of this legislation, because if we undertake that then, as amended and enlarged throughout the coming years, the finger will be pointed to the payment of bills for people well able to pay it for themselves, when you say why withhold it from any part of our citizens regardless of age or anything else.

I appreciate having your comments on that because I think that represents a big departure, the idea of the Government establishing a program for people who do not need it. It does not make sense in my book.

Thank you.

Senator ANDERSON. Does your firm have a retirement program?

Mr. CULLEN. We certainly do, sir.

Senator ANDERSON. Is it payable to a man whether he needs it or not?

Mr. CULLEN. Yes, sir; it is.

Senator ANDERSON. Why don't you put a means test on it?

Mr. CULLEN. Well, sir, the program itself is geared to their earnings, so there is a needs implication in the formula.

Senator ANDERSON. The whole social security system we now have permits people to obtain their retirement pay whether they need it or not.

Mr. CULLEN. Yes, sir.

Senator ANDERSON. If a man retires from business even though he has a million dollars he gets social security.

Mr. CULLEN. Yes, sir.

Senator ANDERSON. Would you advocate a means test for that?

Mr. CULLEN. It is a little to late for that, Senator.

Senator ANDERSON. I think you will find you are too late on this also.

Senator CURTIS. May I say right there, one of the reasons why social security has moved along as it has, has been that the designers of it have told the American people repeatedly that an individual pays for his own benefits. Just last week the actuary for the Social Security Administration said that of the present beneficiaries, what they have already received and what they are expected to receive, they have paid 10 percent, and 90 percent was aid by other taxpayers; and 10 years from now it will vary in degree only about 20 percent. They will have paid for about 20 percent.

I agree with you that the U.S. Government must keep faith with the commitments it has made. But I cannot see that is an argument in this case, for doing something for people who are well able to do it themselves.

Senator BENNETT. Mr. Chairman, there is a kind of means test in social security which is the limitation on earnings after retirement.

Senator CURTIS. You do not have to retire under this.

Senator BENNETT. No. There is this type of limitation on social security. A man who earns more than $1,200 either has his social security reduced or eliminated.

Mr. CULLEN. There is one other difference, too, as I understand it, and again I am not an expert on this matter, Senator. The social

security is evaluated in terms of the taxes necessary on a current basis. It is evaluated on a current basis as we go along. The national health legislation is looking ahead to a considerable number of years in the future, and projecting costs which admittedly seem to be quite low in the present, but which escalate very rapidly into the future, somewhere, I believe in the committee report, it said that something like $8,000 would be required in terms of investment on the part of a young wage earner today by the time he were in position to realize the health benefits at 65.

Senator ANDERSON. Thank you very much.

Mr. CULLEN. Thank you.

(The following was later received for the record:)

CHAMBER OF COMMERCE OF GREATER PHILADELPHIA,
COMMERCE AND INDUSTRY COUNCIL,
Philadelphia, Pa., May 12, 1965.

HON. HARRY F. BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: As a result of our privilege of appearing in public hearings on H.R. 6675, I have the honor to transmit to your committee the attached proposed amendment to the bill. If adopted, this proposed amendment, in the opinion of the Greater Philadelphia Chamber of Commerce, would reduce the cost of the execution of the bill to the taxpayer and to the Government and prevent a miscarriage of its objectives.

For these reasons, we respectfully request that you offer this amendment when your committee is ready to act upon the bill.

Respectfully yours,

GEORGE L. CULLEN,
Chairman, Hospital Task Force.

PROPOSED AMENDMENT TO THE SOCIAL SECURITY BILL (H.R. 6675)

The effective date of the basic and supplementary plans shall be the first of the month following 90 calendar days after the Secretary of Health, Education, and Welfare has caused to be published in the Federal Register the complete administrative regulations and has certified that the following measures have been completed:

1. Development of uniform cost accounting systems for hospitals and cost formulas which give proper recognition to major differences among hospitals as to character of services rendered, teaching facilities, and general costs of the area. Provisions for reimbursement of hospitals to apply only to those hospitals in compliance with this section.
2. Construction of uniform terminology and numerical coding for all medical and surgical services and procedures which are reimbursable.
3. Financial incentive to hospitals to hold down general operating costs and financial incentive to hospitals to transfer patients to long-term care facilities.
4. Development of specific formulas for each region to determine reasonable charges for physicians' services, and maximum dollar limits established by region on each type of service in the supplementary plan.
5. Appropriate notice, review, and appeal procedures provided and completed in connection with the specific content of sections 1–4 above.

Senator ANDERSON. Dr. Hanchett.

STATEMENT OF DR. PAUL E. HANCHETT, EDUCATIONAL DIRECTOR, CHICAGO MEMORIAL ASSOCIATION

Dr. HANCHETT. Senator Anderson, members of the committee, it is a pleasure to be here, and I especially wish to thank Senator Douglas for permitting me to come.

I am an economist, educational director of Chicago Memorial Association. As you can easily see from the statement before you and from a supplementary statement which I submitted for the record, the position I represent is definitely in favor of the bill.

I believe it should be unhesitatingly passed. A more rational system of medical economics for the disfavored segments of our population, such as the aged, at least, is long overdue.

There are four reasons why a system of medical care, paid for, in part, collectively, is more rational than the private-fee-for-service system:

1. Prime necessities of life such as water, air, food, education, and health care must be universally distributed. Whether this distribution will actually prevail, depends upon their price. The cheapness of air and food enables them to be supplied without consumer subsidy—while education and health care, to be widely available, require to be paid for collectively.

2. Ours is an age of secularly rising prices. Over a man's lifetime, the costs of medical care can, and do, substantially rise. But private insurance companies provide no protection against this risk.

3. Increased life expectancy and changing employment practices are augmenting the proportion of a man's life that will be spent in retirement. These extra years, however, are the very ones when medical costs are likely to be especially high. Unfortunately the public has not yet fully realized and made provision for the implications of this longer life. This hazard applied to men and women both, but especially to women.

4. Medical care has become more than a prime necessity of life. It is a precondition to the efficient production and enjoyment of all other commodities. Thus the implications of the consumption of health care far transcend direct health benefits. Collective subsidy is justified by the larger production and consumption of other commodities, that adequate health care alone can make possible.

With your permission, I would like to add just one short note.

Senator ANDERSON. Surely.

Mr. HANCHETT. When our youngest Government department was set up by our Congress about 15 years ago, it was called the Department of Health, Education, and Welfare. This was not a misnomer. It was no accident that this designation was chosen for health and education of the twin strategic social services of our economy. Education and educated people are more healthy, and healthy people can become better educated, and will better educate their families.

These two services complement and reinforce each other, and both education and health lead to welfare.

It is also no accident that health came first, for health today has become more than a necessity; it is a universal imperative, an ultra necessity of life.

Therefore, I say pass the bill, pass it now. Don't let another year or session go by. Every year that we wait is another year of accumulating of the hidden costs that an inadequately structured system of health care has delivered for our older people.

Thank you very much, Senator.

Senator ANDERSON. Are there questions?
Thank you very much. I appreciate your coming for the hearing.
(The supplemental statement submitted by Dr. Hanchett follows:)

WHY GOVERNMENT ACTION IS ESSENTIAL TO PROVIDE HEALTH INSURANCE FOR THE AGED

(By Dr. Paul E. Hanchett, educational director, Chicago Memorial Association)

The campaign to provide voluntary health insurance for the aged has failed. After nearly a decade of intensive underwriting and sales effort by 77 Blue Cross plans, 68 Blue Shield plans, and 870 private insurance companies, the enrollment gap for the aged stands at 40 percent and the benefit gap at 75 percent. That is, approximately 7 million or 40 percent of our senior citizens still have no health insurance protection whatever, and even the 10.3 million who have been covered hold policies which exclude protection against 75 percent of their total health hazards.

The reasons for this unpremeditated tragedy are not to be charged up to lack of diligence by the private insurance industry. Rather, they are inherent in the structure of the medical care market itself. For medical care in our economy has become an unbudgetable commodity, especially for persons like the aged, many of whom are already chronically afflicted. Being unbudgetable, it is not strictly insurable.

Moreover, the attempt to insure medical care for the aged escalates medical prices and threatens the stability of the 154 million outstanding health insurance contracts for young and old alike. Thus, the present predicament is likely to worsen, and the whole future of health insurance in the United States stands in jeopardy.

MEDICAL COSTS FOR THE ELDERLY ARE NEITHER BUDGETABLE NOR INSURABLE

Budgeting and insurance are both prognostic attempts to substitute average costs for actual costs. Two formidable factors, however, prevent the elderly individual—even one whose income is adequate and secure—from budgeting for his own medical expense. Likewise, similar barriers prevent the insurance industry from providing a firm and effective policy in the health insurance field.

In 1961 the average person beyond the age of 65 spent approximately $226 for personal medical care. Such expense would be budgetable if every member of the group experienced approximately the average expenditure or close to it. Unfortunately, such is not the case.

More than expenditures for any other necessity of life, medical outlays fluctuate capriciously and are subject to extremes of dispersion and askewness. Although in 1961, most senior citizens did not spend as much as $226 for personal health care, more than 10 percent of them experienced medical bills in excess of $1,000. Some, of course, were compelled to pay far higher amounts. Furthermore, the incidence of the smaller and larger claims can seldom be known in advance.

Thus it becomes too speculative a venture for an individual, or anyone else acting on his behalf, to budget for his own expense by setting aside deposits based upon the average costs for the whole group. The risk of exposure to a large expenditure that might undermine his whole future, is far too perilous.

A second factor also acts to make medical expenses unbudgetable for the individual. This is the fact that any ascertainable average of medical expenses is always yesterday's average.

In recent years the medical field has become the most dynamic and explosive in the whole economy. Since 1957 medical costs have risen three times as rapidly as the Consumer Price Index and certain components such as hospital costs have risen about six times as fast. In principle the problem of budgeting could still be solved if the future pace and path of medical prices could be forecast. Unfortunately, however, the medical sector of our economy has been a law unto itself—with prices rising sometimes more slowly than other prices, sometimes much more rapidly, and sometimes rising not at all. Until the form of that law has been fathomed and at least some of its determinants have been empirically quantified, firm budgeting for medical care will remain an utter impossibility.

These very same considerations generate strains within the insurance industry such that the insurance companies and Blue Cross also find it difficult, if not impossible, to average. Two requirements are mandatory: first, a reasonably firm average must be obtained in advance; second, it is necessary to find and to hold a nonselected group. The preceding discussion has dealt with the first point by showing that averages of medical costs, insofar as they are definitely known, will always be obsolete. It suffices, therefore, to indicate the virtual impossibility that the private insurance industry can enroll and maintain a nonselected group to which any true average, even if it could be obtained, would validly apply.

In the early days of health insurance the insurance companies went out looking for the better risks. In other words, company selection prevailed. More recently as insurance became more popular and the industry became more competitive, the buyers of insurance, both group and individual, selected the companies so that self-selection prevailed. Either way there is a biased population.

Furthermore, even if a random, nonselected group could be enrolled at the beginning, it tends to deteriorate over time because there is no guarantee that the members of the group will continue their policies. In fact what happens, the purchase of a health insurance contract educates the buyer to a closer attention to the economics of speculation and risk. No one is closer in touch with the facts that control his own health prospects than he. Buyers will discontinue policies for assorted reasons, logical and illogical, but no one lets his policy lapse because he has contracted chronic illness or thinks that he has become sickness prone. The insurance company is left holding on to an actuarially deteriorating group.

The final result is that a randomly selected group fails to be attained because either the insurance company or the insured makes the selection originally, in the renewal of the policy, or both.

In summary, the fundamental reason why health care costs are not a strictly insurable risk today is because they are adversely subject to the hazards of open end averages and open end groups.

THE SELF-DEBASING INSURANCE POLICY

In attempting to come to terms with the conditions of this dilemma, the insurance companies have had to devise a very special contract. They have to put fixed-dollar amounts in it like $15 a day for hospital room and board, and $3 for medical visits. This is not because the insurance companies are inhumane. It is because of the necessities of the situation. But these fixed-dollar benefits—even in the absence of general inflation—depreciate in real benefit value so long as medical costs continue to rise.

Consider a specific case. As early as 1939 North American Life & Casualty Co. was progressive enough to offer a combined hospital-surgical policy with a $150 maximum surgical schedule, that could be purchased during working years and continue on indefinitely into retirement. At time of issue the fixed-dollar benefits sufficed to cover about 50 percent of short-term inhospital charges.

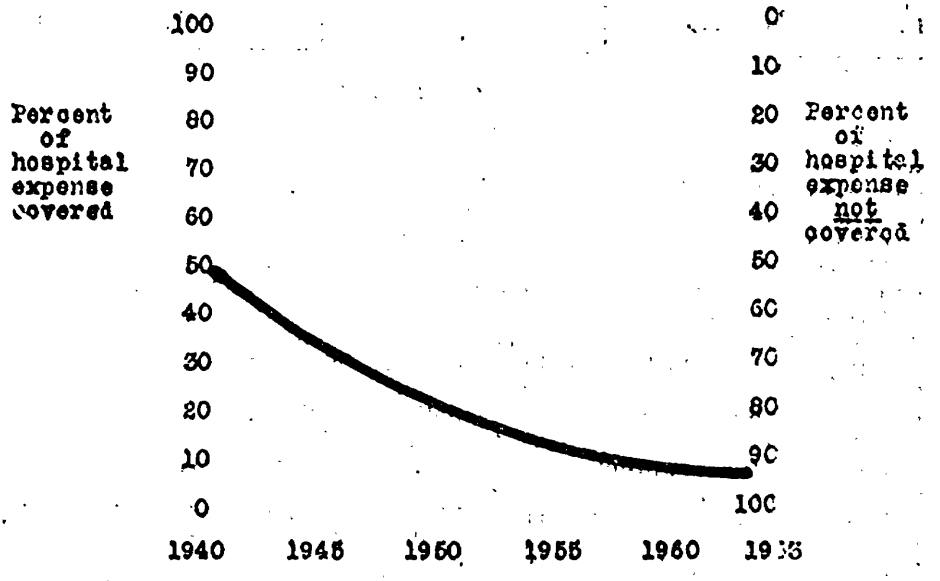
As time went on and hospital costs rose, this percentage of protection steadily declined (table I). Finally in January 1963 when the insured who bought this policy really needed protection during retirement, he went to the hospital and ran up a medical bill of $822.20—of which the policy then covered only $62.20 or about 7.7 percent.

What had been purchased as an up-to-date and effective policy steadily depreciated into trivial protection—at the very time when it was needed most.

TABLE I: Percentage of Inhospital Expenditures Reimbursable for Selected Years under North American Life & Casualty Contract (Policy # 92125; issued October 1, 1939 and still in force).

	1940	1945	1950	1955	1960	1963
Percent of hospital expense covered	50	33	19	13	9	7.7
Percent of hospital expense not covered	50	67	81	87	91	92.3
Fixed-dollar daily benefit	$3	$3	$3	$3	$3	$3
Average daily hospital cost	$6	$9	$16	$23	$32	$39
Annual premium cost	$12	$12	$12	$12	$12	$12

FIGURE I: The Automatic Erosion of Fixed-Dollar Hospital Benefit Contracts, 1940-63 (Data taken from Table I).



GRESHAM'S LAW APPLIED TO HEALTH INSURANCE

There is an even more fundamental reason why any attained level of coverage under private health insurance tends to deteriorate.

Selling health insurance has become somthing like war or a football game. A company cannot stand still. It has to go ahead—it has to sell more and more. A parasitic kind of competition has developed.

After any given level of selling the best risks and the people who most want insurance will be enrolled on the books of some insurance company. The poorer risks and those least interested in insurance will not. Any company desiring to expand volume—as is essential even to stand still in today's market—will realize that its best sales opportunity is to go after a group that is already enrolled. To do so, something must be offered that looks very attractive.

The insurance company has to offer what looks like a lower price, because the market is very cost conscious and because price is objective. But to make it seem even more attractive, what it actually does is to offer a lower price and a better package of benefits at the same time.

This is ordinarily impossible, of course, but the policyholder is neither a CPA nor an insurance actuary. Hence he cannot evaluate the quality of the package, although he can add up the dollar cost. The chaos that finally results is a contemporary adaptation of Gresham's Law: Poor policies drive out good. And poorer companies sell larger volumes than better companies.

Nowhere is this rush by second-rate insurance companies to proliferate inferior policies more prevalent than in the area of health insurance for the aged. Not a single one of the Nation's 10 largest insurance companies offers any guaranteed-renewable major medical or comprehensive policy to persons beyond the age of 65 (table II). Thus the elderly are forced to seek protection from less substantial underwriters which pay out small percentages of their premium income in benefits and which frequently take advantage of the policyholder in the settlement of claims.

TABLE II.—*Senior citizen guaranteed-renewable major medical plans*

[10 largest life insurance companies in the United States]

Company	Deductible	Coinsurance	Maximum benefit	Special requirements	Annual premium
1. Metropolitan	No such plans available for senior citizens				
2. Prudential					
3. Equitable (New York)					
4. Travelers					
5. John Hancock					
6. Aetna					
7. New York Life					
8. Connecticut General					
9. Occidental					
10. Lincoln National					

CONCLUSION

If the insurance industry could write an adequate policy, 57 million policies would be more than enough to cover old and young alike, because there are only about 56 million households in this country. However, under present circumstances the insurance industry knows that it cannot offer an adequate policy and the buyer knows that he cannot buy one.

The tragic result is that both from the side of demand and the side of supply, a proliferation of partial, inadequate enrollments is encouraged.

Although 454 million policies are presently in force—an average of 8 policies for every household—we have arrived at a situation where no conceivable number of policies could be sold that would give adequate, comprehensive coverage. This is because the gaps, the holes, that exist in the policies of one company are matched by gaps and holes in the policies of others.

This problem is one that is too big for the insurance industry and it is too big for the nonprofit corporations. The only redeeming possibility rests with Government.

In dealing with the stubborn problems posed by providing hospital care for the aged, the Federal Government would be favored over the private insurance industry by four distinct advantages:

1. It could obtain an insurance group without adverse initial selection;
2. It could maintain the continuity of a group, once enrolled;
3. It could avoid the parasitic, competitive destruction in the quality of coverage that is inherent in the structure of the private insurance industry; and
4. It alone has the financial power to supplement the contributions of needy persons so as to make an adequate insurance policy possible.

The private insurance industry has not been deficient in energy, determination, or good will. But these are not the problem. Once the Federal Government provides a suitable program for the most pressing needs of the aged, then the private insurance industry may be enabled to put its good intentions to work in devising adequate policies for those who are not beyond the age of 65.

Senator ANDERSON. We will meet again tomorrow morning at 10 o'clock.

(Whereupon, the committee recessed at 12:30 p.m., to reconvene Tuesday, May 11, 1965, at 10 a.m.)

SOCIAL SECURITY

TUESDAY, MAY 11, 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, Smathers, Douglas, Gore, Hartke, Ribicoff, Williams, Carlson, Bennett, Curtis, Morton, and Dirksen.

Also present: Senators Hickenlooper and Sparkman; Elizabeth B. Springer, chief clerk.

Senator ANDERSON. The committee will be in order.

Senator Hickenlooper, we are very happy to have you introduce Dr. Ward to the committee, please.

Senator HICKENLOOPER. Mr. Chairman, I want to express my thanks for your courtesy in permitting me to introduce an old friend of mine from my home State, Dr. Donovan F. Ward, of Dubuque.

We have a great many fine physicians in Iowa, so I couldn't say that he is necessarily the leading one, but there is none better in the State of Iowa and he is a leading physician in the United States, president of the American Medical Association, and he has held various offices in our State association and the national association. I have known him for a good many years. He is devoted to medicine and to better health, and has had a wide experience. He is head of surgery in several hospitals, and with this broad experience and his position as president of the American Medical Association, I think it eminently qualifies him to speak for that association and for the viewpoint of the physicians and surgeons in connection with this legislation.

I again thank you for permitting me to present this old friend of mine of long standing and to listen to his testimony.

Senator ANDERSON. Dr. Ward, may I say I read your full statement last night and it took me nearly 2 hours of hard reading to go through it. I am very happy you have a shorter version today and without objection your full statement will appear in the record, and if members of the committee don't object we will let you go through your statement even though it will run beyond the 15 minutes allotted to you and then have questions on it.

I hope the other witnesses won't worry about that because you represent mainly State medical societies, and I think that speaking for the American Medical Association he should have a little more time.

So, Dr. Ward, you go right ahead and we will let you finish your statement and we will have questions on it.

STATEMENT OF DR. DONOVAN F. WARD, PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY DR. PERCY E. HOPKINS, CHAIRMAN, AMA BOARD OF TRUSTEES; AND DR. SAMUEL R. SHERMAN, CHAIRMAN, AMA COUNCIL ON LEGISLATIVE ACTIVITIES

Dr. WARD. Thank you, sir.

Mr. Chairman and members of the committee, I am Dr. Donovan F. Ward, of Dubuque, Iowa, president of the American Medical Association. With me on my immediate left is Dr. Percy E. Hopkins, of Chicago, Ill., the chairman of the American Medical Association board of trustees; and on my right is Dr. Samuel R. Sherman of San Francisco, Calif., the chairman of the association's council on legislative activities.

We appreciate the opportunity to appear before you today to state our views on H.R. 6675.

We have prepared a longer statement which covers in detail points that cannot be presented fully in this presentation. Because of the limited time allotted to us, my purpose here is to outline as briefly as possible the AMA's basic position on this matter as set forth in our more extensive material. We ask that the longer version of our statement be accepted for the record, and we urge the committee members to spend the extra minutes that may be required to review it. May this be done?

Senator ANDERSON. I previously said without objection the full statement will appear in the record.

Dr. WARD. Thank you, sir.

Through the years, Mr. Chairman, the physicians of the United States have been guided by concepts of medical care which have been developed through study, experience, and personal conviction. We believe, and have consistently held, that all Americans should have available to them the best medical care, when they need it, regardless of their ability to pay for it.

This care is primarily a personal responsibility, but where the individual requires financial assistance, we believe that such aid should come from his family, his community, and where necessary, from all levels of government.

These concepts come in conflict with parts 1–A and 1–B of H.R. 6675. With at least two basic fundamentals do we find serious fault:

H.R. 6675 would provide health care, regardless of financial need, for all persons who have reached the age of 65 years, financed by a payroll tax on younger workers which will increase steadily in the years ahead. We oppose the taxing of these younger workers to pay for the care of those who can meet their own expenses.

Parts 1–A and 1–B of H.R. 6675 would be federally administered and managed programs. We believe, instead that a program which would provide for local administration will best meet the needs of all parties concerned and will permit medical science to continue to flourish.

Accordingly, the AMA urges this committee to reject parts A and B of part 1 of title I of this bill and to substitute S. 820, a bill to enact the eldercare program.

At the same time, we support the adoption of part 2 of title I with certain amendments which we are recommending today.

In your consideration of this bill, you may wish to review our testimony before this committee less than a year ago on H.R. 11865, 88th Congress, the predecessor of H.R. 6675. Included in our statement was a detailed analysis of the progress of Kerr-Mills implementation by the States, the encouraging health and economic status of our aging population, and the magnitude of the unfair tax burden which would be imposed on the Nation's work force to support a federalized hospital program for an entire segment of the population.

This material is as valid today as it was then, and we will not burden this record with a repetition of the same voluminous facts and figures. Instead, we will ask you to look ahead with us and consider other equally fundamental questions. But first we would like to comment on specific provisions of the measure before you.

Beyond our overall objection to part 1–A, or the hospitalization portion of the bill, we note that section 1814(a)(2) (p. 15) provides that payment for services furnished an individual may be made only to providers of services if a physician certifies that the services are or were required. This section applies only to request for payment by providers of service—hospitals, extended care facilities, and home health agencies. It does not include physicians. We note also that section 1835 (pp. 37–38) in part 1–B of the bill carries the same proviso. Our objection to both is the same: It should not be necessary to require the physician to certify the provider's request for payment. Since it is the facility which seeks payment, it should make the certification that the services were furnished to the patient and that he was admitted and cared for upon the advice of the physician.

In part 1–B, as in part 1–A, health benefits are provided across the board for all persons over age 65, regardless of financial need. Here, too, the program would be administered by the Central Government from Washington.

We believe there should be a sliding scale of income eligibility, and there should be State and local administration. We further urge that the program offer the individual a variety of coverage similar to the choices in the successful Federal employees health insurance program.

As it stands, part 1–B offers a single type of standardized protection which is certain to be unsuitable for many. Health care needs are individual problems and must be handled on that basis.

Finally, we believe the insurance carriers should be designated the underwriters of any such program. This would utilize to the fullest the experience of the carriers over a great many years in meeting the Nation's health care needs.

Each of these changes is a fundamental principle of S. 820, the eldercare program, which aroused enthusiastic public support when it was proposed a few months ago by the medical profession. Eldercare was the culmination of long and thoughtful study by the Nation's physicians stemming from their years of experience in caring for the aged. This program remains to this day the only one before Congress that was drafted in consultation with the medical profession.

Also in part 1–B, section 1842(a)(3)(B) (p. 55), there is the provision that the carrier will assure that any charge for services will be

"reasonable." In part 1–C, section 1861 (p. 84), the Secretary is authorized to establish—by regulations—methods to be used, and items to be included, in determining "reasonable" costs. This language could easily be the nub of control in the future, enabling the Secretary to set the range and type of medical services for which payment would be made.

To limit the means by which unnecessary controls could be interjected, the bill should provide in part 1–B that the customary charges by physicians will be recognized by the carriers. In part 1–C the word "reasonable" should be deleted altogether as a further safeguard.

In this or any other legislation you may approve, we strongly urge retention of the provisions of part 1–C, section 1861(b) (p. 63) which eliminate medical specialties from the definition of hospital benefits. The services of pathologists, radiologists, anesthesiologists, and physiatrists are professional medical services which do not belong in a program solely designed to offer hospital benefits.

We recommend that in your deliberations you explore certain facts. Testimony by the American Hospital Association suggests that it seeks for its members ever-widening control over medical care, that it looks toward the inclusion of virtually all specialties within the administrative jurisdiction of hospitals. This would be a highly undesirable development in patient care. Medical care is the responsibility of physicians, not hospitals.

We suggest you inquire whether the separation of specialities from hospital services would not make it more difficult for hospitals to justify excessive charges to patients resulting from operation of laboratory and X-ray departments.

And we also point out that the inclusion of specialists in hospital services would unnecessarily impose an estimated $300 million a year additional payroll tax burden on the program, most of which would be borne by the lower income wage earners.

Section 1861(j) (p. 72) defines an extended care facility. We suggest that the definition be modified to include any nursing home which has been accredited by the National Council for the Accreditation of Nursing Homes as a skilled or intensive care nursing home, or has met the requirements for approval of special health care facilities as established by the American Hospital Association.

Section 1861(k) (p. 74) establishes a plan for utilization review committees to attempt to deal with the anticipated excessive demands for benefits under the program. These should be significant changes in the language of these provisions as set forth in detail in the longer version of our testimony.

Beyond this, we must state categorically that it is unrealistic for Congress to depend on this mechanism to prevent the dangerous overburdening of our health facilities. There is no totally effective method which will keep the cost of the program under control.

The AMA favors part 2 or title I which would establish a new title XIX in the Social Security Act. The new title would encourage States to establish a medical assistance program which aims at equal treatment for all the categorical public assistance recipients. We believe this concept has merit and should result in a more efficient administration of the program. However, we believe certain requirements for a State plan need modification.

For example, paragaph (5) (p. 126) requires that the State agency administering the plan under existing title I or XVI would have to administer, or supervise the administration of, the plan for medical assistance. We urge that the States be authorized to determine for themselves whether a program of medical care should be operated by the welfare department or by the health department.

Further, paragraph (10) (p. 127) provides for making medical assistance available to all individuals receiving aid or assistance under the categorical public assistance grants. We agree with the basic intent of this proposal; it has been AMA policy since 1958. However, we believe that the States should not be required to extend the AMA "medically indigent" principle to the other three federally defined categories of need—blind, disabled, and families with dependent children. We believe this should be optional, not mandatory.

Section 1903(e) (p. 141) requires that by 1975 the States must provide comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, et cetera. If our understanding of the interpretations that are being placed on these provisions is correct, a program to furnish all medical care for all medically needy persons, regardless of age or physical disability, will have to be implemented by 1975. This would have a major effect on our present system of providing medical care for the needy. This section warrants your most careful study.

We also generally endorse title II, part 1, which is concerned with the maternal and child health and crippled children's programs. But here, too, we believe that some of the requirements need clarification as outlined in our longer statement prepared for the record of these hearings.

Title III would amend the Social Security Act in a number of respects. Among these is the provision (sec. 311, p. 218) for compulsory coverage of self-employed physicians under the act. We recommend that the committee reject this proposal. In this, we are expressing an AMA policy of many years standing. Repeated investigation has shown that the overwhelming majority of the Nation's physicians remain active well beyond the social security retirement age of 65. Thus, many would be required to pay social security taxes until age 72 before they could receive benefits. This would be an inequitable arrangement; it represents an unnecessary and unreasonable action toward one group of citizens against the wishes of the majority of that group.

The foregoing represents only the highlights of the amendments to this legislation which the medical profession suggests. Other recommended changes and modifications for each of these sections of the bill and for other sections, are included in the longer version of our statement which has been submitted to the committee.

And now, Mr. Chairman and members of the committee, a few final words. What we have said here, what we will say in the next few moments, may cause no hesitation in this chamber, or stay in the slightest degree the hand of the Senate in the approval of this bill. Yet I hope—I fervently hope—that these words will be carefully weighed.

H.R. 6675, if enacted into law, will affect the lives of all who live today, and the lives of our children and our children's children.

H.R. 6675 will introduce into our way of living an entirely new concept of social welfare. H.R. 6675 will alter the structure of our medical care system for generations to come.

In the face, then, of so vital a stake, should you not once more pause and consider?

The American system of medicine for generations has been a system of quality medicine, practiced through a voluntary relationship between patients and physicians, with doctors free to make decisions based on the patient's specific needs and nothing else.

Yet we have seen the trying problems in other lands—some of which are related in our statement submitted for the record—and the results engendered by centralized government programs to provide health care for a large segment of the population. Long waits, poor equipment and facilities, short, impersonal examinations, and lots of record-keeping appear to be the major accomplishments of nationalized health systems. Can we hope the American plan will be so different as to negate all these adverse factors?

We think not. Forget for a moment the staggering, though unpredictable, cost of the pending program. Ignore the administrative problems that it would create, and the burden it means for wage earners at the low end of the income scale.

Look only at the intrusion of Government in the field of medicine, which cannot be avoided if this measure is adopted. With the quantity of care thus restricted for the sake of controlling costs, the quality must deteriorate. The patient is the ultimate sufferer. But his disillusionment is shared by those who serve him. With the advent of state medicine, professional discontent appears to be the rule rather than the exception. Look again at the experience of the foreign programs.

This may be our last chance to ask you to write legislation which will meet the Nation's needs and at the same time avoid the pitfalls of a Government-financed, Government-controlled, and Government-oriented health care system. This may be your last chance to weigh the consequences of taking the first step toward establishment of socialized medicine in the United States.

While there is still time, we urge you to pause, consider, and act wisely.

(The full prepared statement of Dr. Ward follows:)

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION ON H.R. 6675, SOCIAL SECURITY AMENDMENTS OF 1965, BY DONOVAN F. WARD, M.D.

Mr. Chairman and members of the committee, I am Dr. Donovan F. Ward, of Dubuque, Iowa, president of the American Medical Association. In behalf of the association, let me state that we appreciate this opportunity to appear before you to present our views on H.R. 6675.

We sincerely regret that such an opportunity to be heard on this legislation was not given after it had been drafted by the House Ways and Means Committee. As a consequence, this comittee has now been handed an omibus bill of overwhelming proportions which has not previously been subject to public examination or discussion.

Let me begin by stating medicine's belief that the committee has not only the opportunity, but the obligation, to consider parts of the bill separately.

H.R. 6675, as it is now put together, embodies fundamentals from several previously advanced plans. Watered down from its earlier versions in successive Congresses, the basic hospitalization plan remains the King-Anderson bill. In addition, new benefits have been added through a supplemental insurance program. A third part, not restricted in its application to the aged, would provide

increasing benefits to the needy aged, blind, disabled, and families with dependent children.

The measure also provides increased cash benefits for social security recipients—a proposition to which virtually no objection has been expressed in any quarter.

Medicine has often stated its views concerning these various parts of the bill. It has long advocated that the four public assistance programs under social security be combined into a single program so that in the provision of medical care, uniform services would be made available to the eligible public assistance recipients in the State. It has also advocated the widest possible use of voluntary insurance programs in the furnishing of medical care to the older population.

In the particular area which concerns us here today, health care of the aged, we have a primary medical interest. We were interested in this subject and in the changing patterns in health and disease of older Americans long before these matters became legislative issues.

Medicine has also recognized the necessity of assuring health care to persons in need. For years, we have pursued the goal of finding a means for filling the broad medical requirements of older citizens, who need help in financing their care, while preserving for all Americans the high standards and high quality of our present health care system.

Medicine's support of the Kerr-Mills law, both before Congress and before State legislatures throughout the country, is too well known to require review here. But medicine did not stop here. It began years ago urging the broadening and strengthening of Kerr-Mills by the respective States.

Even this was not enough. Medicine in all its aspects is a science that advances by continual questioning of existing concepts and probing forward with new ideas. Thus, it continued to seek new health care approaches which would provide the greatest amount of care for the needy, in the swiftest and most convenient way possible, and at minimum cost to taxpayers.

Out of these long and careful efforts—during which scores of tentative proposals were examined and rejected—came a series of recommendations by the medical profession for the provision of a wide range of hospital and medical care to people 65 and over who need help in financing these expenses. This program, which soon became popularly known as eldercare, is based directly on the knowledge and experience of the Nation's physicians in meeting the health care needs of the aged for a great many years.

To this day, eldercare remains the only proposal before Congress for providing health care for the aged that was drawn up in consultation with the medical profession.

Medicine's opposition on practical and philosophical grounds to proposals for furnishing hospital and medical care to all persons over age 65 without regard to their need for financial assistance is, as you know, of long standing. That position is unaltered by the introduction of the pending measure.

While we recognize that there are parts of H.R. 6675 which commend themselves to Congress and the Nation, medicine is opposed to this measure as a total package.

Normally, the committee would concern itself primarily with the financial aspects of legislation. But in this instance, it cannot divorce itself from implications and issues inherent in this bill which transcend purely fiscal questions. For at stake here is the decision whether the United States is going to continue to have a system of medicine which is universally recognized as the finest in the world, or whether this Congress is prepared to embark on a course which will interject the Federal Government into the health care of an ever-growing segment of our population.

There is no other way to say it, gentlemen. You are being urged here to approve a historic revision of the U.S. medical system. The pattern thus established would be the same in all essential particulars as that in other countries whose health care today is marked by precarious financing, controls, overburdened facilities, and distracted, frustrated physicians.

On August 13, 1964, the AMA appeared before you and documented medicine's opposition to H.R. 11865, this bill's predecessor in the last Congress. The 96 pages of comments which were then delivered could now be repeated as accurate, logical, and forceful arguments against the adoption of this measure.

But we will not repeat them today. We will not again detail the progress of Kerr-Mills implementation by the States and the continuing improvement of programs in State after State, or of the 10 millions of our older citizens who have purchased health insurance, or had it purchased for them. We will not

repeat the extensive material which we have offered in the past to show that the overall health and economic problems of older Americans have been grossly exaggerated in the campaign to secure enactment of this program.

We will not cite the arguments against burdening the young to pay for Government benefits for the old, many of whom are better off than those who will be paying the bill. We won't dwell again on the undermining effects this program is certain to have on the voluntary insurance systems which have proven their success in financing health care for all Americans, the young as well as the old.

These are things you know and they are not disputed. You doubtless will wish to review our testimony of less than a year ago in evaluating the legislation before you. It is as germane today as it was then.

No, we will not speak of these points except as reference to them is necessary to make clear the principles on which medicine has stood in this long and bitter controversy for almost 20 years. Instead, we will ask you to look ahead with us and consider other equally fundamental questions.

If H.R. 6675 is enacted into law, will we find that the health care problems of our older people will disappear—or even diminish? Can we, by adopting a scheme which has our National Government oversee the financing and distribution of health care for all older persons, look forward to an era of quality medical care for our people? Will many of our intelligent and dedicated youth continue to seek careers in medicine? Will the United States continue to be the center of world medicine and of medical science? Will the medicine needs of all our older people be served in the manner and according to the standards they have known throughout their lives?

What is the answer to each of these questions? We believe it is "no."

There never has been anything simple or easy about this controversy. It is difficult to measure the deterioration of the quality of medical care should this bill be enacted. But as medical men who have spent our professional lives in this field, we can point to factors which, added together, clearly indicate a deterioration of health care under a system of Government controlled medicine as that proposed under H.R. 6675.

The first is overutilization of facilities which will occur despite provisions in the bill to the contrary. There is a quirk in human nature which causes an individual, when he is told he is entitled to a "free" service, or after payment of a modest sum he will be entitled to that service, to feel he must take advantage of the service whether or not he has any real need for it. I urge you not to ignore this very real idiosyncrasy or to take it lightly.

Programs of this nature lead to excessive demands on facilities for minor treatment, which in turn exaggerate shortages in existing facilities and personnel. That has been the experience abroad wherever Government medicine has been established. It will be the experience in the United States if this bill passes.

The bill frankly acknowledges this peril and attempts to deal with it by creating utilization review committees. This device may look sound on paper, but physicians, perhaps more than any others, are well aware of the enormity of the pressure that will be exerted by patients and their families to gain the advantage of Government benefits under the program.

There is no totally effective method or methods which will keep the costs of the program under control. As has been noted, the fact always remains that crushing demands, leading to overburdened facilities, have marked Government-financed health care in each country where it has been tried.

It has been stated that a portion of the increased utilization early in the program would be attributable to treatment of conditions that individuals had not taken care of earlier for one reason or another.

If the record showed that such utilization was a phenomenon peculiar to the initiation of these programs, this might be an acceptable argument. But this is not what the record shows. For example, throughout the first 13 years following the establishment of the hospitalization program in the Province of Saskatchewan, utilization continued to increase. It climbed steadily from 1,564 hospital days per 1,000 population, when the program was initiated, to 2,315 hospital days.

The home environment to which some patients must return after hospitalization must be considered in understanding this problem. Those who are poor and living in depressing circumstances naturally are reluctant to leave a place where they have received kind treatment, good food, and understanding.

Nor should the factor of loneliness be overlooked. All physicians soon learn they must expect instances of patients, particularly among the elderly, who seek

treatment for vague ailments with ill-defined symptoms, merely to have someone to talk to.

The effect of overutilization on the quality of medical care is obvious. If the facilities are being utilized by individuals who have no pressing need for care, or by those whose chronic conditions will receive little or no benefit from their hospitalization, the same facilities will be unavailable to persons who are in immediate need. It would be the height of injustice if the worker who must pay for this program could not get the care he or a member of his family needed because of the program.

Further, it must be understood that every time hospital personnel are required to spend time with a patient who does not have an immediate need for care, that time will not be available to the patient who does have a need. This results not only in frustration of the personnel but in a decrease in efficiency.

Operating costs are also inextricably bound with the peril of overutilization. If facilities are overutilized, there will be a corresponding increase in cost. Imagine the magnitude of the expenditures that would be necessary if the experience in Saskatchewan were duplicated under this program.

When costs get out of line—and let me assure you, they will—there are three possible courses of action. The first is to reduce the benefits; the second is to increase taxes; the third is to impose Government controls on the services in an attempt to control costs. We know welfare benefits are not likely to be cut back once the public has learned to enjoy them. Certainly, constantly increasing taxes are undesirable.

This leaves the third approach—controlling the providing of services. This bill contains the mechanism for doing exactly that. It would extend regulatory authority to the Secretary of Health, Education, and Welfare with respect to the administration of, and medical practice in, participating hospitals. Use of this authority by Government employees to keep the lid on services, thus guarding against expenditures going budgetary limitations, must be expected. Indeed, it cannot be avoided.

Under our system of medicine as we have always known it, treatment of the individual has come first and financing second. The physician has exercised his knowledge and skill to his greatest capacity in each case. But with the emphasis shifting from quality to cost, as it must under a publicly financed program, a deterioration in the quality of care is inescapable.

Many of these problems have been recognized in and out of the medical profession. With the best of intentions, suggestions have been made that the solution lies in the construction of more health facilities and the training of more medical and ancillary personnel. Unfortunately, it isn't quite that simple.

A minimum of a year and a half is required to construct a new hospital, and a minimum of 9 years to train a physician. Under the most optimum conditions, and even if there were unlimited money to spend on an effort of the required magnitude, there plainly would be a serious timelag before pressure on the existing system could be relieved.

Testimony before congressional committees has repeatedly emphasized the need for increased facilities and personnel to meet current requirements and keep abreast of the country's normal growth.

Hearings have disclosed that 20 percent of the positions for professional nurses in hospitals in the United States are now vacant; that 1 out of 10 nursing homes has no full-time professional or practical nurse; that 7 out of 8 of the 13,000 facilities offering "personal care" or "residential care" have no nursing staff.

Members of Congress have also been informed that the States are reporting a need for 133,000 more general hospital beds and some 532,000 long-term beds, with the cost of modernizing and expanding existing hospitals being estimated at $3.6 billion.

These figures represent current needs. How much more will existing and threatened shortages be aggravated by the enactment of parts 1–A and 1–B of H.R. 6675, with its attendant problem of overutilization? What effect can the aggravation of these shortages have on the quality of medical care available to all Americans?

With respect to physicians and dentists, it has been forecast that there will need to be a 50-percent expansion in the number of physicians in training and a 100-percent expansion in dental school enrollments by 1975 merely to keep pace with the population growth.

But one must also consider the student. He is aware that he faces a minimum of 9 years of hard work before he can expect to practice in his chosen field. He

sees his classmates who have entered other fields reap rewards from their education at a much earlier time. Industry and Government programs urge him to enter other scientific endeavors and offer him inducements to do so. Thus, medical schools may have difficulty in continuing to attract the high-caliber students they would like to have.

But when you add to that the prospect of Government control or the threat of Government control as is contained in parts 1–A and 1–B of this bill, you introduce an ingredient that will tend to dissuade the qualified student even more from pursuing a medical education.

For example, England has established scholarship programs for medical schools. And yet the number of medical students in England has decreased steadily to a point where it has fallen below the 1938 level—some 10 years earlier than the establishment of its national health program.

As it reaches you now, parts 1–A and 1–B of this bill represent a new proposal of unequaled dimensions as compared with previously considered Government health programs. The total cost of H.R. 6675 to the Federal Government, including the acceptable features, has been estimated at $6 billion. This is an estimate. No one knows today what the actual burden on the Treasury will be when it attempts to pay for the health care of every person over 65 in the United States, the wealthy and self-supporting as well as the needy.

Only a few months ago, before this committee, we noted the increasing tax burdens on wage earners which these federally financed health care measures will create. First being considered was a raise in the tax base to $5,000, then to $5,200, then $5,400. Our testimony in August 1964, contained the following statement: "In the last few days a figure of $6,600 has been mentioned in this chamber as a possible social security tax base." That figure is no longer a matter of conjecture; it has become a fact established in H.R. 6675.

We know that in each succeeding version of this legislation in recent years, the cost estimates have been revised upward—or the benefits have been revised downward—or both. The inadequacy of the previous cost estimates has been demonstrated and admitted repeatedly. It is significant that, in the short period of time since the King-Anderson measures were introduced in the 89th Congress, the House committee again adjusted the tax structure upward, while decreasing the benefits to be offered. If past history is any indication, and we believe it is, we can be sure there will be further increases voted in the social security tax scales before the stepped-up schedules, as proposed in this bill, through 1987, have been reached.

As we have said many times in the course of this controversy and our appearances before committees of Congress, the issue here is not health care of the aged versus no health care. This never has been the issue.

The medical profession has always held that all Americans who need health care should receive it when they need it, regardless of age or ability to pay for it. We have opposed, however, the underlying principle upon which this measure is based; namely, that there is a need for the Federal Government to provide health care for everyone over the age of 65.

Earlier this year, the American Medical Association presented to the public its program which proposed Federal-State assistance to the aged with a simple income test to determine eligibility. This program, as we have noted, marked the culmination of extensive study and discussion within the medical profession. Utilizing Blue Cross and Blue Shield and health insurance companies as intermediaries, eldercare would authorize State governments to offer the aged a complete range of health care if they cannot afford to meet their own expenses. A burdersome new payroll tax would not be necessary since eldercare would concentrate available resources on bringing aid to those who need it. Millions would not be spent for care of the self-supporting or well to do. We submit that eldercare would be a more efficient and more economical system for providing medical care for the aged than that proposed in the bill before you.

Throughout the years, the physicians of the United States have been guided by concepts of medical care which have been developed through study, experience, and personal convictions. We believe that all Americans should have available to them good medical care. This care is primarily a personal responsibility, but where the individual requires financial assistance in meeting his health care expenses, we believe that such assistance may come from his family, his community, and where necessary, from all levels of government.

These concepts come in conflict with parts 1–A and 1–B of H.R. 6675. In at least two basic fundamentals do we find serious fault. H.R. 6675 would provide health care for all persons who have reached the age of 65 years, without regard

to need for assistance in meeting health care expenses. We strongly disagree with this underlying principle of the bill. Parts 1-A and 1-B of H.R. 6675 would be a federally administered and managed program. Here, too, we strongly disagree. We believe, instead, that a program which would provide for local administration will best meet the needs of all parties concerned and will permit medical science to flourish in a free society.

Accordingly, the AMA urges this committee to reject parts A and B of part 1 of title I of H.R. 6675, and to substitute S. 820, a bill to enact the eldercare program.

However, we have prepared a series of comments on specific provisions in parts 1-A and 1-B which are included in our testimony. We believe this material offered by the medical profession will be helpful to the committee.

At the same time, we support the adoption of part 2 of title I with certain amendments which we are recommending today.

Before turning to these points, we should like for the sake of emphasis to single out three provisions of this measure which merit your most serious attention.

As it stands, H.R. 6675 excludes from inpatient hospital services the services of pathologists, radiologists, physiatrists, and anesthesiologists. In any measure which you report to the Senate, we strongly urge that this language (sec. 1861(b), p. 63) be retained without modification.

The services of pathologists, radiologists, physiatrists, and anesthesiologists are professional medical services performed by physicians. The fact that their practice is largely in the hospital is incidental. These are not hospital services, and they do not belong in a program designed solely to offer hospital benefits. All physicians want to be responsible to their patients to the limit of their competence; they cannot be restricted by decisions of nonmedical personnel on what services should and should not be performed in medical facilities.

If pathologists, radiologists, physiatrists, and anesthesiologists are included in part 1-A of title I, as proposed in Senator Douglas' amendment No. 156, they will be subject to rules and regulations imposed by the Secretary of HEW on hospitals participating in the program. It follows that they will be subject to curbing and direction by Government employees, untrained in medicine, seeking to meet their primary responsibility toward the budget in the only way open to them, through control of services.

There are other compelling reasons why this committee should examine with microscopic care the motives behind the strenuous campaign by the American Hospital Association and its affiliates to restore these specialties as part of hospital services under this legislation.

The following statement from AHA testimony before this committee is revealing:

"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."

We submit that this is more a statement of purpose than a statement of fact. It strongly suggests that the American Hospital Association seeks aggrandizement for its members—ever-widening control over the provision of medical care in this country. Can there be any doubt from that statement that the AHA has its sights on the inclusion of virtually all specialties, not just the four currently under discussion, within the sphere of hospitals' administrative jurisdiction?

It is also obvious that the AHA is endeavoring to enlist Congress as an ally in the furtherance of this objective.

We are aware that Edwin L. Crosby, M.D., executive vice president of the AHA, has stated in a telegram to Senator Paul Douglas that the exclusion of these specialties from the hospitalization section of this legislation would retard the growth of the modern hospital as the "central institution in our health service system."

We strongly disagree that hospitals should become the "central institution" for the provision of medical care. This is not their purpose or their function. The hospital is primarily a place where medical care is provided to patients. Medical care is the responsibility of physicians, not hospitals.

Furthermore, we believe the legislative process should not be used to transform what is now a voluntary association between specialists and hospitals into a compulsory system which, by the force of law, would have the effect of compelling these physicians to become hospital employees whether they were willing or not.

If hospitals are permitted, with the imprimatur of a Federal law, to capture administrative control over one segment of medical practice, the door will be

open to further extension of this authority to other specialties. Will there then be any safeguards against the eventual absorption of all medical practice within hospitals by hospital administrations?

We vigorously dissent from the thesis that the concentration of specialists in hospitals as full-time employees is the avenue to "the best possible patient care at the lowest possible cost." On the contrary, the separation of the specialists from hospital services will undoubtedly reduce costs to patients. It is common knowledge in the profession that in most hospitals, the operation of laboratory and X-ray departments results in excessive charges to patients, charges which substantially exceed the actual operational cost. The inclusion of specialists' services as part of the overall charge tends to obscure these "profits." The separation of these specialties from hospital services under this legislation would undoubtedly make it more difficult for hospitals to justify these charges on a "reasonable cost" basis.

Beyond this, physicians have a far better record than hospitals in keeping the price of their services within bounds. In the past 25 years, physicians' fees have risen only 100 percent while the overall cost of living has increased 115 percent. Hospital costs, on the other hand, have climbed by 405 percent.

Dr. Crosby also stated in his telegram that "the required total separation of the particular physicians' services involved from the departmental costs of hospitals will require nationwide renegotiation of contracts between hospitals and specialists and between hospitals and third-party agencies." This is an exaggeration of a minor problem, more argumentative than real.

The exclusion of these medical services from the hospital program would undoubtedly result in changes in existing procedures for some hospitals and some physicians and carriers. But it would pose no major problem. These arrangements are subject to negotiation now and can be renegotiated easily and without difficulty.

We want to reemphasize, however, that if you force this union by law, you will remove the voluntary character of the existing arrangements and lock great numbers of these specialists into a compulsory system against their will.

Finally, we suggest that the members of this committee consider the financial impact of this proposal on the hospitalization program contemplated in this legislation. Many people, in and out of Congress, are apprehensive over the prospective cost of this program. It should be kept in mind that the inclusion of specialists in hospital services at an estimated cost of $300 million annually would unnecessarily impose an additional payroll tax burden on the program, most of which would be borne by the lower income wage earners.

Our second point concerns the proposal in the bill for compulsory coverage of physicians under social security (sec. 311, p. 218). We strongly object to this provision.

The arguments for compulsory inclusion of all physicians in the system, regardless of their personal desires, simply cannot be applied to individual members of the medical profession. A self-employed doctor rarely retires when he becomes 65. His concern for his patients and his ability to serve them continue beyond his birthday, and, similarly, his patients' needs for his care bear no relationship to a retirement age written into a law.

Surveys on physician retirement have shown that the typical physician would be required to pay social security taxes until age 72 before he would receive benefits. We submit that this section of the pending bill would represent unnecessary and unreasonable action directed at self-employed physicians, and we urge the committee to reject it.

Our third point concerns sections 1863 (p. 89), 1864 (p. 90), 1874 (p. 105), and 1902(a)(5) (p. 126) which deal with the use of State agencies and administration of the programs proposed in the bill. The American Medical Association would like to call the following joint policy statement to the committee's attention:

"Without respect to individual organizational position on the substantive content of H.R. 6675, the American Medical Association, the Association of State & Territorial Health Officers, the American Association of Public Health Physicians, and the American Public Health Association are in unanimous agreement in urging that the health care portions of the program envisioned by H.R. 6675, when and if enacted, utilize the administrative and medical competence to be found in State health departments. It is stressed that this is to be a medical care program rather than a welfare program and requires competent medical direction. The coordination of, and price responsibility for, the program in

each State, whatever agencies be empowered to carry out specific portions of the program, may properly be placed in the State health department."

Beyond these questions, we herewith offer further views on other specific provisions of the bill:

Title I, part 1–A

Section 1814(a)(2) (p. 15) provides that payment for services furnished an individual may be made only to providers of services if a physician certifies (and recertifies, where such services are furnished over a period of time) that the services are or were required. This section applies only to requests for payment by providers of service—hospitals, extended care facilities, and home health agencies. It does not include physicians.

It should not be necessary to require the physician to certify the provider's request for payment. Since it is the facility which seeks payment, it should make the certification that the services were furnished to the patient and that he was admitted and cared for upon the advice of a physician.

The further requirement that, in the case of inpatient tuberculosis hospital services, the physician must certify that the treatment could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable, is without justification. It is hardly likely that the physician would require treatment for a patient which was reasonably not expected to benefit the patient's condition.

Subsection (a) of section 1814(d) (p. 18) further provides that payment shall be made in the case of inpatient tuberculosis hospital services if 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. This provision places the hospital administrator in a position of having to pass upon the medical requirements of the treatment furnished and to determine whether hospitalization "could reasonably be expected to (A) improve his condition or (B) render it noncommunicable." We submit that the order of the physician for such services should be sufficient basis on which the provider may make a claim for payment.

In any event, the requirement that the physician accompany the certification with "supporting material, appropriate to the case involved, as may be provided by regulations," is unnecessary and belies the earlier admonition against Federal supervision or control.

Title I, part 1–B

Part 1–B would provide for supplementary health benefits for the aged. While the program is termed "voluntary," the nature of the program more closely resembles a compulsory health care scheme. Here, as in part 1–A, the benefits are provided across the board for all persons over age 65, whether or not they may be of substantial financial means. Here, too, the program is federally administered.

We believe part 1–B needs certain significant changes.

First, we believe strongly that funds spent on financing health care should be concentrated on bringing aid to those who need it. We urge that there be a simple method written into the bill through which the elderly can demonstrate their eligibility to participate in a program of Government benefits.

Secondly, we urge that the bill be amended to provide for administration of the program at the State and local level.

Both the amendments which we are here supporting are fundamental in S. 820, which was drafted in consultation with the medical profession. We can say categorically that both were framed after long and thoughtful consideration, not only to guard against the needless expenditure of public funds and provide maximum care for those in need in the one case, but also to preserve and protect the independent system of medicine in this country which has accomplished so much for mankind. The enactment of S. 820 in lieu of parts 1–A and 1–B would better serve the interests of the aged in our Nation.

The eligibility requirement need be only a uniform and simplified statement of income as provided in S. 820. Placing the program under State and local administration can be easily accomplished by adopting the S. 820 procedure for taking advantage of the existing Kerr-Mills mechanism.

We note with approval that part 1–B does follow S. 820 in one respect. It would bring prepayment plans and insurance carriers into the program, although not to the extent we should like to see. The bill should go much further and we urge that it be amended to follow closely the pattern of the outstandingly suc-

cessful Federal employees health benefits program. It should offer a variety of insurance coverage, similar to the choices offered in the Federal employees program, from which beneficiaries can select the one fitting the individual desires and needs.

The single, standardized program offered by part 1-B is certain to be unsuitable for many. There should be several alternatives as to types and duration of care to make this program truly effective. Moreover, we believe the insurance carriers should be accorded the role of underwriters, utilizing to the fullest the experience which has been gained by the private insurance industry and prepayment plans.

Further, we offer for your consideration the following recommendations with respect to other provisions of part 1-B of the bill.

Under section 1835 (p. 37), payment to the provider of services requires certification and recertification by the physician. The same objections made earlier as to this requirement in part 1-A are applicable here. Only the provider of services should be required to make any certification as to the services furnished. The certification can include the statement that the services were provided pursuant to the direction of the physician, and the name of the physician can be included in the form.

Section 1840(a)(1) (p. 46) and (b)(1) (p. 47) require that the monthly premiums payable under part 1-B shall be deducted from the social security or railroad retirement benefits paid to the beneficiary. We believe that the individual should have the right, if he so elects, to pay his premium on a direct, voluntary basis.

Section 1842(a)(3)(B) (p. 55) provides that the carrier will assure that any charge for services under the program will be "reasonable." In this context, "reasonable" can mean anything. It opens the door to physician harassment by those directing the program. There are only single steps between questioning a physician's fees, questioning his judgment, and then questioning the course of treatment he has prescribed. We recommend that the term "customary" be used in lieu of "reasonable."

This section should further provide that when questions arise they should be settled with the assistance of the local medical society. This is the procedure which has been successfully employed for years by Blue Shield and private insurance carriers.

Title I, part 1-C

Section 1861 (p. 63) contains definitions which are applicable to part 1-A and part 1-B. In section 1861(i) (p. 71), "posthospital extended care services" are defined as services furnished an individual after transfer from a hospital. The section provides that the patient must be admitted to an extended care facility within 14 days after discharge from the hospital. We believe that this 14-day provision should be expanded to 90 days. This would permit a patient to be placed in a nursing home within the longer 90-day period without the necessity of requiring him to be hospitalized for another 3-day period. The additional provision permitting readmittance to the extended care facility within 14 days after a discharge therefrom is reasonable, but we question under this terminology whether the patient loses up to 14 days in the nursing home since the section provides "such individual shall be deemed not to have been discharged from the extended care facility if readmitted thereto within 14 days after discharge therefrom."

Section 1861(j) (p. 72) defines an "extended care facility." We suggest that the definition be modified to include, in addition, any nursing home which has been accredited to the National Council for the Accreditation of Nursing Homes as skilled or intensive care nursing home, or has met the requirements for approval of special health care facilities as established by the American Hospital Association.

Section 1861(k) (p. 74), which deals with utilization review, provides that where circumstances require, the review may be made by a group from outside the facility. We suggest that lines 20-23, page 74, be changed to read "(i) which is established by the local medical society; *in establishing such group, there may be participation by some or all of the hospitals and extended care facilities in the locality;* or (ii) if * * *."

We suggest, if this mechanism is to be used, that subsection (4) (p. 75, lines 10 through 15) be amended to read as follows: "(4) for prompt notification to the institution and to the individual, through 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."

Further, we believe that this subsection should be amended to provide immunity from civil liability for physicians and others who serve on the utilization review committees established under the bill. We can visualize circumstances surrounding admissions and discharges, as well as other actions which may be required of review committee members, in which such liability could arise.

While we are on this matter, we again voice our earlier warning that too much reliance is placed in this legislation on the utilization review procedure as a safeguard against excessive demand and overburdening of facilities.

In a number of instances, utilization review committees have proven their value and have accomplished the objectives for which they were conceived. But these were under normal circumstances. The situation which will obtain when millions of elderly Americans seek benefits they believe themselves entitled to under this program will be anything but normal.

Section 1861(l) (p. 76) relating to "agreements for transfer between extended care facilities and hospitals" as well as all other sections referring to such agreements should be stricken. We can see no necessity for restricting the number of qualified licensed extended care facilities, nor do we see that such a provision is necessary in order to assure that proper medical information concerning the patient will be available. The requirement of an agreement could have the effect of placing qualified nursing homes under fair competitive disadvantage.

In the event this subsection is not deleted, we would recommend that the words "essential to assuring" (p. 77, line 6) be stricken and the phrase "desirable in order to assure" be substituted therefor. This would permit the inclusion of a nursing home which has attempted in good faith to enter into an agreement with a hospital, where the Secretary finds that to include the nursing home under the provisions of the bill would be in the best interests of the community.

Section 1861(n) (p. 79) requires that a plan covering home health services be established within 14 days after discharge from a hospital or extended care facility. As previously recommended with respect to admission to extended care facilities, we believe the period should be extended to permit the plan to be established within 90 days.

Section 1861(t) (p. 83) limits the drugs and biologicals to be made available in hospitals and extended care facilities to those included in certain compendia and publications or to those which are selected by the pharmacy and drug therapeutics committee of a hospital. The AMA feels that this definition is an unnecessary restriction on the physician in his treatment of his patient. With respect to compendia, there is always a delay in new drugs being added to the list. With respect to the therapeutics committee, chaos could result in that not only would the physician be restricted in his choice of drug (which is made on the basis of the individual patient), but different hospitals in the same area may have differing formularies.

The American Medical Association believes that adequate protection of the patient is provided under the existing food and drug law. We can see no reason why a drug which has met the requirements of that law should not be prescribed if the patient's condition warrants it. Therefore, we would urge the deletion of section 1861(t).

Section 1861(v) (p. 84) is concerned with reasonable cost and is the section which may be the nub of control in the future. For the present, it calls for payment of "the reasonable cost of any services." The Secretary is given authority to establish in regulations methods to be used and the items to be included in determining the costs. With this authority he is given the potential for controlling medical care in the future. We suggest that the word "reasonable" be deleted in order to limit the means by which unnecessary controls could be interjected.

Section 1866(d) (p. 96) provides that if the Secretary finds there is a substantial failure to make timely review of utilization of long-stay cases in a hospital or extended care facility, he may, in lieu of terminating an agreement with the facility, decide that with respect to any individual admitted to the hospital or facility after a date specified by him, no payment would be made under the program after the 20th day of a continuous period of services. We recommend that there be 60 days' notice required under this subsection to preclude the possibility that a patient will be penalized although he himself is not at fault.

Section 1869 (p. 101) provides for determinations of eligibility for benefits and appeals by the individual. Subsection (b) would authorize the individual to ob-

tain a hearing if the controversy involves benefits under part 1–A in excess of $1,000. It is our understanding that the sum originally was to be set at $100, but that the figure was increased for housekeeping purposes. We believe that the right of appeal should not be seriously curtailed by setting an unrealistic sum as a requirement for the appeal.

Section 106 (p. 114) would amend the Internal Revenue Code with respect to medical expense deductions. On the one hand, it would grant a deduction to every taxpayer of one-half the amount (up to a maximum of $250) which he spends for health insurance. The American Medical Association supports this deduction as an incentive to the individual to purchase his own health insurance protection.

On the other hand, this section would remove the current exemption from the 3-percent rule with respect to medical expenses and the exemption from the 1-percent rule with respect to medicine and drug expenses which have been granted to the aged. The American Medical Association opposes these provisions as a step backward. We strongly urge that this committee reject these latter changes contained in the bill.

At the same time, the association urges that the committee give favorable consideration to the following three suggested amendments to the Internal Revenue Code with respect to the medical expenses of the aged.

For persons who have attained age 65, we propose the using of a credit against tax liability instead of a medical expense deduction. The tax credit should be related to the amount of his income and to his medical expenses so that a taxpayer who has a burden of medical expenses which is large in proportion to his income will receive the greater amount of tax relief.

Our second proposed code amendment would permit taxpayers over age 65 to receive full tax benefits for medical expenses by use of the carryforward and carryback method. The code now permits businesses to offset losses in 1 year against profits in another year. We believe that it would be equitable to apply the carryforward and carryback mechanism to the medical expenses of elderly persons. If the medical expenses of a taxpayer who has attained age 65 are unusually high in 1 year, he should be permitted to carry back (or forward) the "excess" so that the tax benefits will not be lost to him. We therefore recommend that the code be amended to authorize for these taxpayers a 3-year carryback and a 5-year carryforward for unclaimed medical care deductions.

Our third proposed code amendment is to permit a taxpayer to deduct in full the amount paid for the medical care of any person who has reached the age of 65 and is within the named group of persons defined as dependents under section 152 of the Internal Revenue Code.

Under existing law, a taxpayer is entitled to deduct without limitation the amount he has spent for the medical care of his parents or his wife's parents who are his dependents and who have attained age 65. However, with respect to his sisters, brothers, grandparents, or other dependents who have attained age 65, the general rule applies which permits the taxpayer to deduct only those medical expenses which exceed 3 percent of his gross income. There appears to be no reasonable basis for restricting the taxpayer to a smaller deduction merely because the dependent is not a parent. The financial hardship to the taxpayer is the same regardless of the degree of family relationship.

Another inequity is the requirement of dependency before a taxpayer can deduct for the medical expenses which he has paid for another person. Under existing law, unless the taxpayer has contributed more than one-half of a person's support, the individual is not a dependent and the amount paid by the taxpayer for the medical care of the individual is not deductible. Permitting the taxpayer to deduct his contribution toward the medical care of an elderly relation will encourage family responsibility. It will also make it unnecessary, in those cases where it might otherwise be so, for the aging persons to convert to cash necessary income-producing assets in order to pay for their medical care.

Title I, part 2: "Grants to States for Medical Assistance Programs"

The American Medical Association favors part 2 of title I, which would establish a new title XIX in the Social Security Act. In essence, this new title would provide that after July 1, 1967, the Federal Government would make contributions to the States for medical care for all their public assistance recipients only if the State has established a medical assistance program which meets the requirements of this title. In the main, we believe that this concept has merit in that the provisions of the title will require equal treatment for all our public assistance recipients. It should also result in a more efficient administration of

the program. However, we believe that certain of the requirements for a State plan require modification.

Section 1002 (p. 125) establishes the requirements for a State plan under the program. Paragraph (2) establishes a minimum of State financial participation for the period before July 1, 1970. It also provides that after that date, the financial participation by the State would have to equal all the non-Federal share. This provision would preclude any contribution from the local level. The association believes that if the individual or his family cannot provide for him, the responsibility passes to his local community. We recommend, therefore, that the provision in existing law which simply says that the State plan must "provide for financial participation by the State" be substituted for this requirement.

Paragraph (5) (p. 126) requires that the State agency administering the plan under existing title I or XVI would have to administer, or supervise the administration of, the plan for medical assistance. We would remind the committee that the new title is concerned solely with the provision of medical care. It would seem appropriate, therefore, that the States should be authorized to determine for themselves which agency should administer the program.

Paragraph (10) (p. 127) provides for making medical assistance available to all individuals receiving aid or assistance under the categorical public assistance grants. We agree with the basic intent of this proposal to consolidate the medical care programs for the four categories of assistance. It has thus been AMA policy since 1958. However, we believe that the States should not be required to extend the MAA "medically indigent" principle to the other three federally defined categories of need (blind, disabled, families with dependent children). We believe that this should be optional, not mandatory.

Paragraph (12) (p. 128) requires that in determining blindness, the examination is to be conducted by a "physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select." The determination of blindness is a medical determination which requires complete knowledge in diagnosis and treatment of systemic diseases from which blindness may result. It is our understanding that it is the practice of the Department of Health, Education, and Welfare to refer all individuals about whom such a determination has been made to a physician for a final determination. Therefore, we recommend the deletion of the phrase "or by an optometrist."

Paragraph (13) (p. 129) sets out the type of care that would have to be offered to recipients. It also provides that after July 1, 1967, a State plan for medical assistance would have to provide for payment of reasonable costs for inpatient hospital services "in accordance with standards approved by the Secretary." We believe that the State should pay the customary cost of all services provided. We further believe that the States are capable of developing the required standards, and we can see no reason for the provision that the Secretary must approve the standards.

Paragraph (18) (p. 132) modifies the provisions as to lien recoveries under existing public assistance laws. In a conference on Kerr-Mills conducted by the American Medical Association this last January, a consensus held that lien laws were of no particular value. Many States reported that the costs of recovery exceeded the amounts recovered.

We would also like to note our wholehearted support of the requirements in the State plan that this medical program be under the supervision of professional medical personnel, that limit legal responsibility to spouses and to parents for their children, that require flexible income standards in determining eligibility, and that call for simplification of certification procedures.

We not and endorse the provisions which authorize payment for care for aged individuals in tuberculosis and mental hospitals. We also not that the bill (pp. 137–138) requires that payments could be made for institutional care only in the event that the State demonstrates it has increased total mental health expenditures. We do not see the relevancy of requiring that payment for tubercular care be based on increased mental health expenditures.

Section 1003(e) (p. 141) requires that by 1975 the States must provide "comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources," etc. The bill does not define "comprehensive care and services" nor is it clear as to the extent of the beneficiaries who are designated as "substantially all individuals who meet the plan's eligibility standards with respect to income and resources." We understand this provision is being interpreted to mean that by 1975 all medically needy individuals in the State, regardless of age or physical disability, will be

eligible for assistance under the program. We further understand that "comprehensive services" may be interpreted to mean all 14 services listed on pages 142 and 143 of the bill. If these projected interpretations are correct, a program to provide all medical care for all medically needy persons, regardless of age or physical disability, will be implemented. Such implementation would have a major effect on our present system of providing medical care for the needy. This section warrants careful study.

Title II, part 1

Part 1 of this title is concerned with the maternal and child health and the crippled children's programs. While we generally endorse this part of the bill, we believe that some of the provisions need clarification.

The bill amends section 504 of the Maternal and Child Health Act and section 514 of the Crippled Children's Act to provide that payment could not be made under either program after the end of fiscal 1966 unless the State makes a showing that it is extending the provisions of both programs in the State with a view to making such services available by July 1, 1975, "to children in all parts of the State." The question arises as to whether this language means to all children in the State, or to all needy children in the State. We believe it should mean the latter, and that appropriate qualifying language should be added.

Section 203 (p. 148) of the bill would add a new section to the crippled children's program under which grants would be made to institutions of higher learning for training of "professional personnel" for the health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps. We believe there are existing grant programs which are available to provide for training of professional personnel, and would recommend additional consideration of this section to avoid duplication of existing programs.

Section 204 (p. 148) would amend the provisions of the maternal and child health and crippled children's program establishing requirements for State plans to provide that the State plans for these programs would, after July 1, 1967, have to provide for payment of the "reasonable" cost of inpatient hospital services in accordance with standards approved by the Secretary. As we stated earlier, we believe the State should pay the "customary" cost of such services.

Section 205 (p. 149) of the bill establishes special project grants for comprehensive health care for school and preschool children. The beneficiaries of this program are not properly identified. The section refers to children and youth "particularly in areas with concentrations of low-income families" but additional language refers to children who do not otherwise receive the care "because they are from low-income families or for other reasons beyond their control." This program should be properly limited to children from low-income families. In addition, the terms "preschool" and "school" age should be defined to clearly express the intent desired, and to avoid an interpretation that would encompass an age range extending from infancy through college.

Our final comment on this provision is that we believe it to be incumbent upon this committee to determine that there is coordination between this program and the maternal and child health and the crippled children's programs as they would be amended by the bill, the program of aid to families with dependent children, the vaccination assistance program, the elementary and secondary education program, the economic opportunity program, and the numerous other grant-in-aid programs under which children may receive medical care, so as to avoid duplication as much as possible.

Title III: Social security amendments

This title would make numerous amendments to the OASI and disability insurance provisions of title II of the Social Security Act. We would, however, urge again that the committee delete the provision (sec. 311) (p. 218) which provides compulsory social security coverage for self-employed physicians and for interns and residents.

The American Medical Association, which represents more than 70 percent, or approximately 200,000 of the physicians in this country, has, since 1949, opposed inclusion of physicans under title II of the Social Security Act. It is a policy that has been adopted by our house of delegates over and over again.

For reasons stated earlier, we submit that this section of the pending bill would represent unnecessary and unreasonable action directed at self-employed physicians. We urge the committee to reject it.

Section 303 amends the definition of disability by eliminating the requirement that the impairment be "expected to result in death or be of long-continued and

indefinite duration." This, in effect, would permit disability payments for a temporary disability so long as it extends over a period of 6 months or more. We believe that the character of the program should continue to be one which is based on a concept of permanent disability. Accordingly, we recommend that the definition which now exists in the law be retained.

Concerning this amendment, we note that section 1862 (pp. 87–89) provides that "no payment may be made under part A or B for any item or service for which payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State." This provision would eliminate duplication of medical benefits and hospital, or nursing home benefits to an injured worker already covered by workmen's compensation, but it would do nothing to prevent duplication of compensation for loss of wages from the workmen's compensation system. Furthermore, if the change in definition is retained, it would greatly increase the number of individuals who might receive both workmen's compensation and OASDI benefits for loss of wages owing to temporary total disability. H.R. 6675 does not, therefore, reestablish the so-called offset provision which was enforced through 1958, and which required OASDI to reduce its income benefits by any amounts already being received from workmen's compensation.

Under H.R. 6675 it is possible for an individual to receive social security disability benefits for a temporary disability while he is also receiving workmen's compensation. We believe that this may lessen the individual's incentive to return to work. We urge that the offset provisions be reinserted so that individuals cannot receive double benefits.

We trust that foregoing suggestions will be helpful in the committee's deliberations. We further believe that the experience of the American Medical Association and its members would contribute to any discussions concerned with development of any program, and we stand ready to cooperate in this regard.

And now, Mr. Chairman and members of the committee, a few final words. What we have said here and what we will say in the next few moments may cause no hesitation in this chamber or stay in the slightest degree the hand of the Senate in the approval of this bill. Yet I hope—I fervently hope—that these words will be carefully weighed.

H.R. 6675, if enacted into law, will affect the lives of all who live today, and the lives of our children and our children's children. H.R. 6675 will introduce into our way of living an entirely new concept of social welfare. H.R. 6675 will alter the structure of our medical care system for generations to come.

In the face, then, of so vital a stake, should you not once more pause and consider?

You are familiar with the inscriptions on the National Archives Building which read: "What is past is prologue" and "Study the past."

To try to gain a glimmering of the shape of things that portend as a direct result of the action you are being asked to take, let us examine the past. Let us look for a moment at government medical systems in other parts of the world. Have national medical schemes resulted in medical, health, or economic gains? Has the health of the public improved or made gains which surpass those in our country? Has medical science advanced in countries with socialized medicine schemes, comparable to its progress in the United States? Have there been economic gains to their people?

The answer is "No" to all of these questions. For example:

The physician in Germany, working under the Government insurance plan, sees an average number of patients ranging from 50 to 100 per day, with some physicians processing as many as 80 to 40 patients per hour. The average office consultation in German panel practice is 6 minutes, and the practitioner in industrial areas sees 40 to 60 patients in his office and makes some 15 to 25 home visits per day. With a 10-hour day, this allows at most only 7 to 10 minutes for each patient for examination, history taking, prescription, travel time, and certifications.

In Russia, the citizen has a very limited choice of physicians and can hope for a consultation time of 6 to 10 minutes, with the largest part of that time devoted to form filling and other paperwork. The patient is not so much treated as he is "processed."

In Great Britain, in 1960, the average principal general practitioner had 2,287 patients on his list. On an average of six visits and consultations per patient per year, and in a 49-week year, the physician rendered 280 items of service per week, or 47 per day on a 6-day basis. This averages out to five visits and consultations per hour, or one every 12 minutes. Again, this includes time for travel,

recordkeeping, the issuance of certificates, history taking, and physical examination.

In Sweden, patients complain of long hours of waiting to see the physician, of disrupted diagnostic procedures, of lack of privacy, and above all, of the difficulty of getting assurance of continuous treatment by the same doctor and a good heart-to-heart talk with him. These complaints are readily understandable when we see that about 40 percent of all medical care outside of hospitalization is provided by hospital outpatient departments, where the great number of patients to be treated in a short time makes personal contact difficult.

And so the examples go. There is no statistical evidence to advance any theory that socialized medicine schemes have resulted in an improvement in health beyond that enjoyed by the people still served by private systems of medical care. As seen above, the contrary is the cases. Long waits, poor equipment and facilities, short impersonal examinations, and lots of recordkeeping appear to be the major accomplishments of nationalized health systems.

The disillusionment of the patient is shared by those who serve him. The doctor is appointed as the unwilling guardian of the treasury to ration the scheme's benefits. With the advent of state medicine, professional discontent appears to be the rule rather than the exception. Look at these events of the last 12 months:

In Belgium, a strike by 10,000 Belgian physicians was ended when the Government conscripted most of the M.D.'s into the army and ordered them back to work. Last November about one-half of Belgium's physicians struck again, for 24 hours, to protest against reforms they contended would bankrupt the hospitals.

Italy has had two strikes in the last year. The last one took place on April 12, 1965, when 20,000 doctors in Italy's public hospitals began a nationwide strike to support demands for higher pay and a hospital modernization program and changes in staff appointments.

Physician walkouts were threatened in both Germany and Sweden, but were headed off.

In March, 1965, the British Government narrowly avoided a strike by Britain's family physicians. They asked for more pay and also complained strongly of the health care facilities which are paralyzed by slum conditions and outdated equipment.

These are a few recent examples of the problems faced by physicians which were engendered by government programs to provide health care for a large segment of the population. Can we hope that the American plan will be so different as to negate all these adverse factors in the other systems?

The question answers itself. There is nothing in the history of nationalized medical care systems which can lead us to hope our experience will be unique. The programs in effect in the foreign countries differ from each other, in some cases markedly. Yet they are similar in that they provide government-controlled, tax-supported health care for all, or a large segment of the population, without regard to needs of the people for financial assistance. This concept is fundamental to H.R. 6675. We can hope for no better results here.

The American system of medicine for a great many years has been a system of quality medicine, not mass production medicine. It is a system of private medicine, practiced by private doctors treating private patients, free to make decisions based on the patient's specific medical needs and nothing else.

Forget for a moment the staggering, though unpredictable, cost of the pending program. Ignore the administrative problems that it would create, and the burden it means for wage earners at the low end of the income scale.

Look only at the intrusion of Government in the field of medicine, which cannot be avoided if this measure is adopted. With the quantity of care thus restricted for the sake of controlling costs, the quality must deteriorate. The patient is the ultimate sufferer. Look again at the experience of the foreign programs.

The adoption of H.R. 6675 will set a pattern difficult in the extreme to reverse. This program cannot be tried out and easily canceled if it proves unsatisfactory.

This may be our last chance to ask you to write legislation which will meet the Nation's needs and at the same time avoid the pitfalls of a Government-financed, Government-controlled, and Government-oriented health care system. This may be your last chance to weigh the consequences of taking the first step toward establishment of socialized medicine in the United States.

While there is still time, we urge you to pause, consider, and act wisely.

Senator ANDERSON. Senator Williams?
Senator WILLIAMS. No questions.
Senator ANDERSON. Senator Ribicoff?
Senator Carlson?
Senator CARLSON. Mr. Chairman, only this: I appreciate very much Dr. Ward's testimony this morning because I am somewhat familiar with the operations, not necessarily of the National Medical Association, but certainly the Kansas Medical Association, with which I have worked as a Governor of a State and as a Representative in Congress for many years, and I have found that they usually come in with good sound advice, and I am pleased with the statement made by Dr. Ward this morning which calls attention to some of the problems that I see confronting us in the future in regard to the possible costs of this program.

You go into detail in several of your sections but I was interested in your statement where you discuss 1903 in regard to where we may be heading in the future, an action which will have to be implemented by 1975.

I appreciate your calling our attention to it because it is one thing that has concerned me.

I thank you very much.
Dr. WARD. Thank you, sir.
Senator ANDERSON. Senator Curtis?
Senator CURTIS. Dr. Ward, what kinds of the practice of medicine have you been engaged in?
Dr. WARD. In general surgery, Mr. Curtis.
Senator CURTIS. How long have you been a doctor?
Dr. WARD. Thirty-five years.
Senator CURTIS. Why is it that doctors have opposed medicare which will start out as hospitalization, and now it is hospital plus medical care for all the people over 65 regardless of need.

What is the basic objection?
Dr. WARD. The basic objections have been the Federal control of the system, and that it is not based on need. There is no logical responsibility of the Federal Government in this area.
Senator CURTIS. How does our system of medicine compare with other medical systems around the world at the present time?
Dr. WARD. I think that our system is the finest medical system in the world.
Senator CURTIS. Would you briefly cite some things that prove that?
Dr. WARD. Well, I think probably one of the greatest things is the advancement in the scientific fields, in the fields of diagnosis, in therapeutics, and techniques. The fact that, since 1948, approximately 29 of our doctors have been winners of the Nobel Prize for Scientific Achievement.
Senator CURTIS. Compared to the rest of the world?
Dr. WARD. Yes, sir. When we compare it with Great Britain since its nationalization of medicine in 1948, I believe there has been only one such physician designated.

Their rate of hospital construction has definitely come nowhere near approaching our advancement in this field.
Senator CURTIS. I can recall when I was a boy on a farm in Nebraska our family doctor went to Vienna to study. It was common practice

for medical students and young doctors to go to Vienna, Rome, Berlin, and elsewhere to study.

Is that the trend now?

Dr. WARD. No, sir; it is just the reverse.

Senator CURTIS. All of these countries do have some sort of system of government medicine?

Dr. WARD. Yes, sir.

Senator CURTIS. Where are the young doctors and medical students of the world gathering for the finest and best instructions?

Dr. WARD. In these United States, sir.

Senator CURTIS. Then, would you say that we need a Government health program in order to improve our medical system in this country?

Dr. WARD. No, sir.

Senator CURTIS. Our problem then narrows down to the fact that since we have the finest medical system, the problem so far as the public is concerned is that part of our population over 65 do not have the income and resources to avail themselves of the system that is around them; isn't that right?

Dr. WARD. Yes, sir.

Senator CURTIS. So when we meet that problem, we have done what should be done in the public sector; is that your opinion?

Dr. WARD. Yes, sir.

Senator CURTIS. I am thoroughly convinced that if the young people and the middle aged, those near retiring, are taxed heavily to provide free hospitalization and free medicine to individuals over 65 who may have unlimited capital assets, some of them may have the highest income of their lives and a great many of their burdens such as buying homes, paying for life insurance, and educating their children have gone by, they don't even have to retire under this, I am thoroughly convinced if our people are taxed to pay for medicine for them, that it is only a matter of time when there will be proposals in Congress to extend this free care to people below 65, and it will be done.

Dr. WARD. Yes, sir.

Senator CURTIS. How old are you?

Dr. WARD. Sixty.

Senator CURTIS. You expect to practice medicine for a few years?

Dr. WARD. I hope to, sir.

Senator CURTIS. But, this program will have its impact for many, many years to come.

What is your best objective opinion as to what such a course would do to the practice of medicine, not from the doctor's standpoint but from the patient's standpoint, if we launch something here that is almost inevitably going to be expanded?

What is going to be its effects on the future medical and health system so far as the patient is concerned in the years that lie ahead?

Dr. WARD. I think that the service will deteriorate so far as the patient is concerned. We know that when the budget controls the practice of medicine there is only one individual who suffers, and he is the patient.

Senator CURTIS. Has that been the history in other lands?

Dr. WARD. Yes, sir.

Senator CURTIS. Do you see any reason why it shouldn't be here?

Dr. WARD. Yes, sir; why should we sacrifice first-rate and top-rate medicine for what has been a failure in other countries?

Senator CURTIS. Now, do you find that all people over 65 as a class have a hard time paying their bills they owe you?

Dr. WARD. No, sir.

Senator CURTIS. How do you find the situation with respect to young people in their twenties and thirties and forties and so on who are raising youngsters and educating them and maybe paying for their own education and buying homes and so on, do some of them have some difficulties?

Dr. WARD. Yes, sir; they do.

Senator CURTIS. Would you say that perhaps some of the heaviest or most difficult financial burdens to carry for medical purposes is with the younger and middle aged?

Dr. WARD. It is very definitely.

Senator CURTIS. And you have no objections to hospital and medical service being provided for the older people who cannot provide it for themselves?

Dr. WARD. None, sir. We have supported this.

Senator CURTIS. And you are not advocating that they have to show they are paupers but that you want some reasonable showing that they ought to have some help; is that right?

Dr. WARD. A simple statement of income; yes, sir.

Senator CURTIS. Now, I want to ask you something else.

Frankly, we live in a day where it is rather fashionable in some sections to ridicule and criticize our physicians. I do not agree with them. You probably have some people in your profession who are scalawags. There are a few in politics who are. But I do not share any such view. I think you have a noble profession and the fact that every person in every family has respect for and confidence in the family doctor is one of the finest tributes I know.

Now, tell me in a layman's language, if you can, why it will result in the long run in better medical care, if this bill passes, if these specialists, radiologists, and the pathologists, what are the other two?

Dr. WARD. Anesthesiologists and physiatrists.

Senator CURTIS. Yes.

Why should they be dealt with as other doctors, as independent practitioners, rather than under the hospital section?

Dr. WARD. Because the services of the radiologists, pathologists, anesthesiologists, physiatrists are trained medical men; they render medical services. These are not hospital services, and we feel that if they are included under the hospital portion that this will lead to control, and that it will pave the way for other specialties to be taken into the hospital system.

Senator CURTIS. Isn't it also true that if they are considered as part of the hospital apparatus, the patient in the hospital who does not require the services of these specialists pays a portion of it and it is for bed costs?

Dr. WARD. This is true. Yes, sir.

Senator CURTIS. Long before this issue was raised in this bill here, I visited a new hospital in my State where the per diem rate per bed was about $12 or $13 below the national average and below our larger cities and I asked why. They said primarily, "We do not have the pathologists and radiologists and so on here, and that other hospitals do carry it as part of their hospital, absorb it in their general operation, and it increases the costs of the beds."

Do you think that is true?

Dr. WARD. Yes, this is common knowledge among the profession.

Senator CURTIS. You as a surgeon know that is true?

Dr. WARD. Yes.

Senator CURTIS. And does it also lead to the hospital collecting more for the services of these specialists than in return is paid to the specialists?

Dr. WARD. Yes.

Senator CURTIS. I think that is all.

Senator ANDERSON. Senator Douglas?

Senator Morton?

Senator MORTON. Doctor, on the first part of the questions by Senator Curtis he brought up this matter of going to Europe to study 50 years ago. He said when he was a young man his family doctor went. Much later than that, when I was a young kid, my father went to Germany, he was an M.D., and he went to Germany, I hate to admit it but this was 52 years ago, so I could substantiate this. He would not be going there were he alive and practicing today, he would not be going there for his studies, and I think it is significant, too, the Duke of Windsor, when he had some trouble, could go anywhere in the world, came to this country, in fact, to Houston, Tex., I believe, for a very delicate operation in which this country has established a reputation.

I want to thank you, too, Doctor, for your forthright statement.

Dr. WARD. Thank you, sir.

Senator ANDERSON. Senator Gore?

Senator GORE. No questions.

Senator ANDERSON. Senator Smathers?

Senator SMATHERS. No questions.

Senator BENNETT. Mr. Chairman, I was not able to be in the hearing room during your statement but I just heard the tail end of Senator Curtis' questions.

Do you think a solution of this particular problem, relating to specialists might be to allow those doctors who prefer to practice through the hospital and have their fees paid collected by the hospital to do that, and those individuals who prefer to practice as individuals and present their own bill should be allowed to do that?

Dr. WARD. By contractual arrangements—voluntary, of course.

Senator BENNETT. It seems to me that in a given hospital, if there is a doctor who prefers to render that service as an individual physician, and make his own arrangement with his patient he should have that privilege, and if there are doctors who would be very happy to make a contract with the hospital under which the hospital provides their services and collects—and pays them for it, on any basis mutually satisfactory that they should be permitted to operate on that basis under this law.

Dr. WARD. As the bill is now written, he can still do that voluntarily—and he can also do it ethically. We don't believe, however, that his right should be frozen by the legislation.

Senator BENNETT. You would prefer to keep the door open for those individuals who want to practice as individuals and present their own bill.

Dr. WARD. Yes.

Senator BENNETT. Thank you very much.
Senator ANDERSON. Doctor, you say that—

each of these changes is a fundamental principle of S. 820, the eldercare program, which aroused enthusiastic public support.

Did the polls ever indicate it aroused enthusiastic public support?
Dr. WARD. Yes, sir.
Senator ANDERSON. They did?
Dr. WARD. Yes, sir.
Senator ANDERSON. Which ones?
Dr. WARD. Opinion Research Corp. of Princeton, N.J.
Senator ANDERSON. Yes.
Was that financed——
Dr. WARD. Yes, sir; it was financed by the American Medical Association.
Senator ANDERSON. Did you get the verdict you wanted?
Dr. WARD. It was the verdict of the people, sir.
Senator ANDERSON. Was it?
Dr. WARD. We didn't ask for an opinionated report. We asked for a survey.
Senator ANDERSON. You didn't trust the Gallup poll?
Dr. WARD. The Gallup poll? Yes, sir; we remember the Gallup polls.

The Gallup poll on January 4, 1965, stated that when they asked people if they knew the provisions of the medicare bill—the King-Anderson bill—40 percent of them did not know what it really meant. They were misinformed as to what it covered. They thought it was, shall we say, the whole ball of wax. They thought it included medical services, surgical services, hospital, and drug services, which it does not. Thirty-seven percent had no idea of what the contents of medicare, the King-Anderson, and the tax bill, was, leaving 23 percent of the people having some knowledge of the contents of the bill.

Senator ANDERSON. I thought we were talking about the enthusiastic public response to eldercare?

Dr. WARD. Yes, sir. This was manifested in a public opinion poll in the State of Iowa which showed that four out of five Iowa people preferred eldercare over medicare.

We also know, according to the Opinion Research Corp. of Princeton, N.J., poll taken between March 6 and March 26, 1965, that 74 percent of the people favored eldercare, 14 percent medicare, and 12 percent had no opinion.

Senator ANDERSON. Do you suppose that is why the Congress is supporting it?

Dr. WARD. No, sir. I don't know why the Congress is supporting it. I think the flood of mail into the Congress was overwhelmingly in favor of eldercare.

Senator ANDERSON. You discussed the study by the Nation's physicians stemming from their years of experience, that this program, this eldercare program remains this day the only one before Congress that was drafted in consultation with the medical profession?

Dr. WARD. I am speaking of the American Medical Association, which represents the greatest segment of physicians.

Senator ANDERSON. That isn't what you say, Doctor. I would agree with you if you said it was the only one proposed by the American Medical Association. That isn't what you say, is it?

You say it is the only one before Congress that was drafted in consultation with the medical profession.

Now, are you still wanting to assert that?

Dr. WARD. I stand on that statement, sir.

Senator ANDERSON. You still assert that?

Dr. WARD. Yes, sir.

Senator ANDERSON. Well, are you acquainted with Senator Javits?

Dr. WARD. By name.

Senator ANDERSON. He had a panel: There was a man named Folsom, you may have heard of him, the Eastman Kodak Co., onetime Secretary of Health, Education, and Welfare; Dr. Arthur Flemming, onetime Secretary of Health, Education, and Welfare. He had some doctors with him and he had some drafting of provisions.

Would you say this was consultation with the medical people?

Dr. WARD. Were these medical people?

Senator ANDERSON. One was Prof. Dickinson Richards of New York, who was a Nobel Prize winner; you ruled him out.

Dr. WARD. Did I rule him out?

Senator ANDERSON. That is what I thought.

Dr. WARD. Yes.

Senator ANDERSON. We had a long discussion in the provisions of the King-Anderson bill and I became persuaded that a doctor in California had some good ideas, a man named Dr. Alex Gerber, he is a member of the American Medical Association, I believe, and you represent him, as you do others.

He came to Albuquerque and spent a long time discussing the provisions of the King-Anderson bill and made some valuable suggestions, so valuable that I asked the Department of Health, Education, and Welfare to ask him to come to Washington. They had an interesting discussion with him.

Would you say that was consultation with the medical profession?

Dr. WARD. I am not qualified to speak for Dr. Gerber, I don't know what his qualifications are.

Senator ANDERSON. He is a professor and a very fine practicing surgeon and, if income is any yardstick, he does quite well. I was called—I was reminded of that by a man named McMillan, who is a scientist. I was having dinner with some scientists from the jet propulsion laboratory in California and they spoke about Dr. Alex Gerber and I said, "How did you know about him?"

They thought he was an interesting personality. But you would not think consultation with him was medical. We had a man named Dr. Spock down here who had something to do with babies.

Would you regard him as a member of the medical profession, do you?

Dr. WARD. If he has a doctor of medicine degree, yes. But I think he is a baby specialist and does not take care of elderly people.

Senator ANDERSON. He doesn't have a degree, you say?

Dr. WARD. I didn't say that, sir. I said if he has a medical degree I would assume he is a doctor.

Senator ANDERSON. You don't know of Dr. Spock then?

Dr. WARD. If you qualified him as being a baby specialist which would take him out of the realm of the elderly.

Senator ANDERSON. Are you an elderly specialist?

Dr. WARD. After a fashion, yes.

Senator ANDERSON. Well, maybe he is after a fashion. [Laughter.] Well, did you ever hear of a Dr. Russell Lee in California?

Dr. WARD. I am sure that my colleague, Dr. Samuel Sherman, knows him. I would refer your question to him.

Senator ANDERSON. Yes.

Dr. SHERMAN. Yes, I know Dr. Russell Lee very well and I respect him very highly and I consider him a great authority. I think, Senator, that the point is that we feel that this statement is valid, because the vast majority of the medical profession had not been consulted, nor had the representatives of the vast majority.

You have consulted individual physicians some of whom are very competent, and very capable. But we felt that consultation should have been made with our professional organization which represents the vast majority of physicians in this country.

Senator ANDERSON. You mentioned a while ago the Duke of Windsor going down to Houston.

Did he see a Dr. De Bakey?

Dr. WARD. Reportedly so.

Senator ANDERSON. What is Dr. De Bakey's attitude toward the King-Anderson bill?

Dr. WARD. I haven't any idea, sir.

Senator ANDERSON. It would be interesting.

Dr. WARD. I haven't studied his report on the King-Anderson bill.

Senator ANDERSON. We had 20 highly recognized doctors in a room for a while discussing this problem and knowing that you still insist that it was not drafted in consultation with the medical profession?

Dr. WARD. I am speaking for the body which represents the greatest number of physicians in this country, sir.

Senator ANDERSON. But that isn't what your statement says, is it?

You get on this question of customary and reasonable charges. You want to take out the word "reasonable."

Dr. WARD. Yes, sir.

Senator ANDERSON. That is going to lead to socialized medicine if you leave that in, you say.

What about HIP, what did it do about regulating charges?

Dr. WARD. I didn't understand, sir.

Senator ANDERSON. The health insurance plan in New York. You are in the medical profession, aren't you?

Dr. WARD. Yes, sir.

Senator ANDERSON. You have heard of these organizations like Blue Cross and Blue Shield, and HIP in New York; what is its position on this matter?

Dr. WARD. I think they have a fixed-fee schedule.

Senator ANDERSON. They do.

Does that destroy medicine? I appreciate your contribution.

Dr. WARD. I don't think it does.

Senator ANDERSON. I don't think so, either. They try to make them reasonable.

You object in your prepared statement, in your long statement, not the short one, which I read last night, to changes in the base.

What is your objection to the change in the taxable base, going from $4,000 to $4,200, to $4,600, to $5,600—what is your objection to that?

In your statement, at least that is what my note says—I hope I didn't write it down wrong—you said only a few months ago before this committee that the most increasing tax burden on wage earners to first consider was a raise to $5,000, then $5,200, then $5,400, then $6,000.

Do you think that is good or bad?

Dr. WARD. We think that this is bad because it takes away more from that already heavily burdened segment of our population, the younger people.

Senator ANDERSON. Do you believe in the progressive income tax?

Dr. WARD. Yes, sir.

Senator ANDERSON. You do?

Dr. WARD. Yes, sir.

Senator ANDERSON. Now, this has a medical tax against people who make up to $4,800 and $5,600 and a greater tax against people who can make $6,600.

Do you think that is fundamentally wrong? Isn't that the same principle involved in the progressive income tax?

Dr. WARD. We don't object to the change in the base.

Senator ANDERSON. You don't?

Dr. WARD. We are just pointing out the increasing cost of the bill and the tax increases needed to meet it.

Senator ANDERSON. You don't object to the base then?

Dr. WARD. We just noted it, sir.

Senator ANDERSON. I was going to give you the fact at a base of $4,800, then 66 percent of all workers will have their total earnings covered.

If you bring it up to $5,600 then 74 percent of all workers will have their taxable earnings covered.

If you bring it up to $6,600, which was objected very strenuously to the other day, 81 percent of all workers will have their earnings covered.

I have an income from another outside interest in another business; is it wrong if my base is $6,000 or $6,600 as against a worker's base of $3,000 or $4,000?

Dr. WARD. I don't say that this is wrong. The only thing is that there should be a limit to it. Income that is above the base is not providing an equitable share, I don't believe, in the tax structure. I am not a tax expert. I merely bring to your attention the fact that the taxes are increasing and the base is increasing.

Senator ANDERSON. We have tried to show some reason for a hospital care bill, and I pointed out in this hearing two or three times the only study I know anything about is the study made by the Health, Education, and Welfare Department which shows in 1963 the Social Security Administration found that an aged couple who don't receive free care provided by Government or other agencies without charge had average hospital costs of $442 a year. That is the average of them.

But if one of them was hospitalized the total medical costs went up to $1,220. If they were not hospitalized, the average was $233.

Would you think those figures indicated a need for some watching of the hospital situation?

Dr. WARD. Yes, sir.

Senator ANDERSON. You think it is wrong to provide against those extra costs?

Dr. WARD. On the basis of need.

Senator ANDERSON. Well, if the bill goes——

Dr. WARD. Not for everybody over 65.

Senator ANDERSON. Pardon?

Dr. WARD. Not for everybody over 65. But based on need, this is different.

Senator ANDERSON. You don't believe in the social security bill at all then, do you?

Dr. WARD. I didn't say that, sir.

Senator ANDERSON. Well, I will ask a question that may lead to it. If a man is a working man and retires at 65 and under social security he gets $200 a month, shouldn't he draw it whether he needs it or not if he has paid his premiums?

Dr. WARD. I didn't know that there was a vested right in it.

Senator ANDERSON. What is a vested right? I heard that argument for 5 hours one day; what is it?

Dr. WARD. Are you speaking now of hospital care or benefits?

Senator ANDERSON. No, I am talking about the social security program in general.

Dr. WARD. We have no objection to that.

Senator ANDERSON. You have no objection to that?

Dr. WARD. No, sir.

Senator ANDERSON. If you don't object to providing it for his rent and other bills, why do you object to it for hospital bills?

Dr. WARD. In the first place, it should be based on need.

Senator ANDERSON. Well, wait a minute.

It isn't in the other case at all. If a man comes to the age of retirement and has a million dollars he can draw his social security whether he needs it or not.

Dr. WARD. Yes, sir.

Senator ANDERSON. You don't mind it as long as it isn't in your field.

Dr. WARD. No, sir; I didn't say that.

Senator ANDERSON. What did you say?

Dr. WARD. I object to the inclusion of people who are able to take care of themselves.

Senator ANDERSON. These people in social security who paid their money over a period of time, they are allowed to draw their social security, whether they need it or not.

Do you object to that?

Dr. WARD. We have no argument about that.

Senator ANDERSON. You don't object to that?

Dr. WARD. We are concerned with health.

Senator ANDERSON. It is only when you get to your field that you object to it, isn't that right?

Dr. WARD. After a fashion, yes, sir.

Senator ANDERSON. Thank you.

I have no further questions.

Senator SMATHERS. Mr. Chairman, may I ask a couple of questions? Doctor, how many doctors are in the American Medical Association?

Dr. WARD. Approximately 205,000.

Senator SMATHERS. What percentage of the doctors of the United States belong to the American Medical Association?

Dr. WARD. I would say approximately 76 percent.

Senator SMATHERS. Is it your view as president of the American Medical Association that the majority of the doctors in this association do or do not favor this particular bill?

Dr. WARD. I believe I have expressed the opinion of the vast majority of the members of the American Medical Association in my statements this morning.

Senator SMATHERS. When you say that you believe you express the opinion of the vast majority of the members of the AMA, how do you arrive at this conclusion? You are the president of the association. Are you authorized by your group to speak for the association?

Dr. WARD. Yes, sir, by the house of delegates, which took action February 9, 1965, supporting 100 percent the eldercare program, and 100 percent opposition to the medicare program.

Senator SMATHERS. It would not, therefore, be unreasonable for you to state as you have that most of the doctors of this Nation do not favor this particular bill that we now have under consideration?

Dr. WARD. That is correct, sir.

Senator SMATHERS. That does not mean I agree with you; I am just trying to establish the fact as to whether or not you do represent the thinking of most of the doctors which I happen to think that you do.

Dr. WARD. Yes, sir.

Senator SMATHERS. Doctor, let me ask you this: With respect to the inclusion of doctors under social security, has the medical profession as such ever run a poll as to what the doctors want to do?

Dr. WARD. I believe this has been done in individual State polls.

Senator SMATHERS. First, you are saying that as far as the American Medical Association is concerned it has not run a poll?

Dr. WARD. This is correct, sir.

Senator SMATHERS. So the only poll that we have which would reflect whether or not individual doctors want or do not want to be covered by the social security program would have to be determined by State organizations in the polls which they may have run?

Dr. WARD. The house of delegates has taken this action, Senator, and has rejected the inclusion of the physicians under social security system. This has been done on several occasions.

Senator SMATHERS. The house of delegates.

Dr. WARD. Yes, sir.

Senator SMATHERS. Of course, you are aware of many respected physicians who do desire to be included under social security.

You yourself have knowledge of some doctors who do wish to be included, do you not?

Dr. WARD. Yes, sir.

Senator SMATHERS. Just as an estimate, how many or what percentage of the doctors in your organization desire to be covered under social security?

Dr. WARD. I have no definite knowledge of how many would want inclusion under the social security bill.

Senator SMATHERS. As president of the American Medical Association, you would give to each doctor the right, would you not, if we were able to work it out here, the right to come under the provisions of social security if he wanted to?

Dr. WARD. Yes, sir; on a voluntary basis.

Senator SMATHERS. That is all I have to ask at the moment.

Senator ANDERSON. Senator Dirksen, do you desire to ask questions? Senator Hartke?

Senator HARTKE. Thank you, Mr. Chairman.

Doctor, you are really opposed to any type of program basically along these lines; isn't that true? Isn't that the position of the American Medical Association?

Aren't you really opposed to any type of program whether it be under the so-called Kerr-Mills approach, or the King-Anderson approach?

Dr. WARD. No, sir; we supported the Kerr-Mills approach and have done it both before this body and——

Senator HARTKE. All right, what is there in the Kerr-Mills approach that seems to you to have such outstanding features?

Dr. WARD. In the first place it is based on need.

Senator HARTKE. I understand.

Dr. WARD. It has local administration.

Senator HARTKE. It is what?

Dr. WARD. Local administration.

Senator HARTKE. Well, it is administered through the welfare departments; isn't that true?

Dr. WARD. In some States, yes, sir; and in other States it is administered through the health department.

Senator HARTKE. In your fact sheet, though, you complain about the fact that under medicare it would be administered through the welfare department. That is what you say. Yet in my own State of Indiana the welfare department administers the Kerr-Mills bill. Have you objected to that portion?

Dr. WARD. No, sir; we have not objected. We have left this up to the local States to do this; that is, left it to the individual States to make this decision.

Senator HARTKE. Well, well——

Dr. WARD. If it happens in Indiana that it is the wish of the people in that State, the medical profession in that State, and the legislature in that State——

Senator HARTKE. Do you feel this Kerr-Mills approach is really providing the type of assistance that should be given throughout the United States to all States, to all people on a uniform basis?

Dr. WARD. It has that potential; yes, sir.

Senator HARTKE. Yes; I understand that.

Let's come back. The truth is that you and I know, and all the people who are acquainted with this program know, that the Kerr-Mills program is only operating to a small extent and only in a few States; isn't that true?

Dr. WARD. No, sir.

Senator HARTKE. What is not true about that?

Dr. WARD. It is operating in the majority of the States.

Senator HARTKE. But to all major intents and purposes, I say it is operating in just a few States.

There is no real dispute about that. You say "potentially" it can operate in all of them, and I am not going to argue with potentialities. But the truth is that at this moment, more than 4 years since its passage, only three or four States are using most of the funds, the Federal funds; isn't that true?

Dr. WARD. No, sir.

Senator HARTKE. What is not true about that?

Dr. WARD. May I refer that particular question to Dr. Sherman, please?

Senator HARTKE. You can refer to anybody you want to. I just want to clear up some of these fuzzy ideas. Even one of your own sponsors of the eldercare program had to clear up some of your statements, didn't he?

Dr. WARD. I will enlarge on that after you hear Dr. Sherman, sir.

Dr. SHERMAN. I would like, sir, to offer for the record a special issue of the Medical Legislative Digest of the American Medical Association entitled "The Kerr-Mills Law, Public Law 86-778."

This gives a complete synopsis of the implementation and administration of the Kerr-Mills law since it was enacted and it compares, State by State, what is provided.

Senator HARTKE. I didn't ask you what it provided. I said where the money was being spent.

Dr. SHERMAN. And how it operates.

Senator HARTKE. What?

Dr. SHERMAN. And how it operates.

Senator HARTKE. I didn't ask how it operates.

Dr. SHERMAN. And the type of services.

Senator HARTKE. I didn't ask about the service. I asked a simple question of where the Federal money was being spent. There is no confusion about this, really, except the confusion attempted by certain people who are opposed or not in favor of certain programs. But the truth is that most of the Federal money has gone into a maximum of five States; isn't that true?

Dr. SHERMAN. It has gone into a maximum of anywhere between six and eight States——

Senator HARTKE. All right, in 4 years.

Dr. SHERMAN (continuing). Who have provided local funds to match the Federal funds according to their own local needs.

Senator HARTKE. That is right. And the truth of it is that in all——

Senator ANDERSON. Five States make 68 percent of all payments, gets 66 percent of the funds, had 51 percent of all recipients but only 31 percent of the aged. The States like New York, Pennsylvania, and California can afford it and get the money. States that can't afford it don't; isn't that correct, Doctor?

Dr. SHERMAN. Yes.

Senator ANDERSON. We all recognize this.

Dr. WARD. Mr. Chairman, may I ask permission for Mr. Bernard Harrison, our legal counsel, to make a statement?

Senator ANDERSON. You will make it, I hope, Mr. Harrison, on the subject Senator Hartke raised. Are five States getting most of the money? If you have contradictory evidence put it in.

Mr. HARRISON. Yes; may I reply to that, gentlemen?

Senator ANDERSON. Yes.

Mr. HARRISON. It is true a certain small number of States, five, six, or eight, various figures have been used, have received the most cash under the Kerr-Mills program, but there have been some misleading statistics involved here.

First of all, the percentage that is used—the percent of the aged of the country—is applied to the entire country; that is, 31 percent of the aged in the entire country. Yet we are speaking only of the aged under Kerr-Mills.

There are some 40 States or so which have Kerr-Mills programs. When we speak of the percentage of the aged that are covered we speak of all the aged in the country. There is some variance there.

Furthermore, the programs——

Senator HARTKE. Wait a minute.

Who has confused who? You say it was a matter of confusion of the statistics. I listened to everything you said and I understood it and I wasn't confused. I don't think I have said anything, or that Senator Anderson said anything, in contradiction of what you said.

Mr. HARRISON. The 31-percent figure that I heard—does that apply to the number of aged throughout the whole country, 31 percent of the aged of all the country, the entire 20 million?

Senator ANDERSON. We can change the figure for you very quickly—38 percent of all the aged in those States which have in effect Kerr-Mills program get 68 percent of all the payments.

Mr. HARRISON. Thank you very much. I think that figure then presents a correct picture.

Then I would like to make the second point if I may.

The second point that I make, sir, is that the States which have expended the greatest sum of Kerr-Mills funds are generally the States which have had a program inaugurated or implemented for the longest periods of time.

Senator HARTKE. Let me ask you a question.

Mr. HARRISON. They have had an opportunity then, Senator, through experience, to provide a program with greater benefits.

Senator HARTKE. All right. That is a fine statement, and I don't see anything wrong with it. But let me ask you a question.

When did the Federal law say that one State or another State could not, if they desired to do so, enact immediately or any time they wanted to?

Mr. HARRISON. It never said so.

Senator HARTKE. Then what is the purpose of saying here that some States went ahead and took advantage of the Federal law first and therefore they are getting more money? So what? I think we should say, "God bless them."

Mr. HARRISON. That is an explanation only, sir, that these State programs have been in existence the longest time and if you will check, sir, since the inauguration of the Kerr-Mills program those percentages have come closer together.

In other words, given the opportunity for these programs to develop, experience indicates that use of Federal funds will approximate relating population.

Senator HARTKE. That is exactly right, "given the opportunity." What opportunity has been denied to any State to put in the program whenever they wanted to?

Mr. HARRISON. No opportunity, sir, except——

Senator HARTKE. You said, "given the opportunity."

Mr. HARRISON. Except, sir, given the time involved, sir.

Senator HARTKE. Given the time. Who put a time limit on any State in the Union?

Mr. HARRISON. This is a natural time limit, sir, when the State legislatures meet only approximately once every 2 years.

Senator CURTIS. Would the distinguished Senator from Indiana yield?

Senator HARTKE. Yes, sir.

Senator CURTIS. I think that a study of how long it took the States to avail themselves of the money in other titles of the Social Security Act would be quite significant. Some of them took much longer than they did on Kerr-Mills, and it is not unusual that some States move in rapidly and some take a little longer.

Also some of the States that are cited here as having a rather poor experience on Kerr-Mills have, within recent months, made provision for an expanded and more liberalized program.

Senator WILLIAMS. Would the Senator yield for one observation?

Senator ANDERSON. I would be very happy to have it put into the record.

Senator CURTIS. Mr. Chairman, I have caused to be prepared a statement and a table comparing the time taken by the States to avail themselves of the Kerr-Mills program as compared to the length of time taken by the States to initiate vendor payments under old-age assistance and aid to families with dependent children.

(This comparison and table are as follows:)

STATE PERFORMANCE ON KERR-MILLS LAW—SLOW OR FAST?

About 4½ years ago Congress enacted the Kerr-Mills medical assistance for the aged program.[1] Supporters of social security "medicare" say the States have lagged badly in initiating this grants-in-aid program for elderly persons unable to meet some or possibly all of their medical expenses.

Have the States lagged?

As of May 12, 1965, 40 States had medical assistance for the aged programs in operation. Three other States are in the process of implementation: New Mexico's program will begin on July 1; Montana has enacted enabling legislation; and in Nevada, a bill has passed both houses and is awaiting the Governor's signature. The remaining seven States either need to enact legislation or have authority for medical assistance for the aged but do not plan to initiate a program in the near future.

Thus, the record shows that in 4½ years, 40 of the 50 States—80 percent of them—have medical assistance for the aged programs in effect.

Is this performance slow or fast?

One way to evaluate performance is to compare the length of time it has taken the States to establish vendor payment[2] programs under old-age assistance and aid to families with dependent children, with the length of time it has taken them to initiate the Kerr-Mills program. You will recall that Congress added vendor payments to public assistance in 1950.

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[1] The Social Security Amendments of 1960 (Public Law 86-778) were approved Sept. 13, 1960.

[2] "Vendor payments" are payments made by the welfare department to the supplier of medical services (doctors, hospitals, etc.). This is the way elderly persons (under both old-age assistance and medical assistance for the aged) and families with dependent children obtain needed medical care.

As the following table shows, in 5 years only 12 States—25 percent of them—had initiated vendor payments under old-age assistance and aid to families with dependent children. And, 9 years elapsed before as many as 40 States had vendor payments under old-age assistance. It took 12 years before that many States adapted the vendor payment method under aid to families with dependent children.

Actually, it was not until 1962—12 years after Congress passed the law—that all States had vendor payments under old-age assistance. By the end of 1964 nine States still had not begun vendor payments under aid to families with dependent children.

The record is clear—States have moved much faster in implementing vendor payments under Kerr-Mills than they did in adapting this method in old-age assistance and aid to families with dependent children.

State implementation of vendor payment medical care provisions under old-age assistance (OAA) and aid to families with dependent children (AFDC), 1950–64

Calendar year	Number of States initiating program during calendar year		Cumulative total	
	OAA	AFDC	OAA	AFDC
1950	5	5	5	5
1951	5	5	10	10
1952	2	2	12	12
1953	None	None	12	12
1954	None	None	12	12
1955	2	2	14	14
1956	4	3	18	17
1957	13	13	31	30
1958	5	3	36	33
1959	4	3	40	36
1960	2	1	42	37
1961	3	2	45	39
1962	5	1	50	40
1963	----	1	----	41
1964	----	None	----	41

Source: For basic data, see "U.S. Department of Health, Education, and Welfare, Characteristics of State Public Assistance Plans Under the Social Security Act, Provisions for Medical and Remedial Care," Public Assistance Report No. 49, 1964 edition, p. 193.

Senator WILLIAMS. Will the Senator yield at one point?

Senator HARTKE. Let me just say this, sir, to you. I understand, and I think everyone here understands, that the official position of the American Medical Association is to oppose the King-Anderson bill. We understand the statements you have put out. We understand the propaganda. We understand the money that has been spent, and I don't think it helps any for you to fuzz up the facts. When you put out statements which say that you are going to provide a wider range of medical care—and this is the impression your pamphlets have consistently left with the people—that you are going to get more coverage, more benefits, at less cost, then this is as misleading as it can be. There is at the basis of all these bills only one question, and that is: How you are going to pay the bill? I haven't seen one hospital, one doctor come before this committee and ever say that his bill is going to be reduced because of the payment, because of the enactment of this legislation or anything we have ever done. We are talking about how to pay the bills and, when you say it can be done for less, this leads the people into a false anticipation of a realization which will never occur.

Dr. WARD. Need is the basis for it. Therefore, it would take in a smaller segment of those over 65. Therefore, you can render more services to a limited group than you can——

Senator ANDERSON. When you say "the need" you recognize that in 15 of the jurisdictions that have the Kerr-Mills bill if a married couple has as much as a $1,500 life insurance policy they are ineligible.

Don't you think they might have need even though they had a $1,500 life insurance policy?

Dr. WARD. If there is a demonstrated need; yes, sir.

We also believe that had the Secretary of Health, Education, and Welfare——

Senator ANDERSON. Just a minute. You say if there is a demonstrated need. I said the possession of a $1,500 life insurance policy excludes them. In 19 States a $2,500 life insurance policy excludes them, no matter what they show about need other than that they are ineligible if they have as much as a $1,500 life insurance policy.

I gave you some figures here between a thousand dollar figure if they have hospitalization with one member of the family and no hospitalization and you think a $1,500 life insurance policy should make them ineligible?

Do you?

Dr. WARD. This, in our program, the eldercare program——

Senator ANDERSON. We were talking just a minute ago of Kerr-Mills.

Dr. WARD. The Kerr-Mills. Eldercare program is an expansion of the Kerr-Mills bill.

Senator ANDERSON. Does Congressman Mills so recognize it?

Dr. WARD. I don't know.

Senator ANDERSON. I thought he put another bill in. How did I miss it? I thought he put another bill in.

Dr. WARD. There were changes made in our bill.

Senator ANDERSON. There certainly were—for the better, I hope. All right.

Senator WILLIAMS. Doctor, if the needs test under the Kerr-Mills bill is too restrictive, that is as a result of State action and not as a result of the bill itself as passed by the Congress; is that not true?

Dr. WARD. That is correct.

Senator WILLIAMS. And is not also one of the major reasons that the Kerr-Mills bill was not implemented more rapidly by the respective States is that since its enactment in 1960 the Department here in Washington has been discouraging the States and propagandizing against the Kerr-Mills bill trying to keep it from enacting it in order that they might force the King-Anderson bill or some medical bill of its comparison into law?

Dr. WARD. We believe this is true, sir.

Senator WILLIAMS. I know in our own State representatives of the department have spoken against it and even to the extent that last year there was such a confusion created that the Governor of the State thought the Kerr-Mills bill had been implemented when it is not implemented in reality and the first payments are going out in 1965.

Dr. WARD. Yes, sir; we believe had the Secretary of HEW given support for the Kerr-Mills bill, it would have been implemented more rapidly in all of the States.

Senator ANDERSON. Thank you very much.

Dr. WARD. Thank you, sir.

Senator DOUGLAS. Mr. Chairman, I do not wish to address a question to the representatives of the American Medical Association, but I wonder if it might be in order if I ask that a statement from Dr. Albert W. Snoke who is executive director of the Grace-New Haven Community Hospital in New Haven, be inserted in the record at this point. I would like to read, if I may, certain paragraphs which deal with the question as to whether the services of medical specialists given inside the hospital should be reimbursable under the basic hospitalization plan where the hospital bills for the services and pays the specialists.

Would that be appropriate?

Senator ANDERSON. Will you put it in the record at this point?

Senator DOUGLAS. Can I call attention to one point? Dr. Snoke furnishes an account of the expenses in the cases of two patients, one a 79-year-old man who was operated on for cancer of the prostate gland, and the second a 75-year-old female operated on for cataracts. This shows that in the case of the man if the billing is on an individual basis there would be bills from the two personal physicians plus nine additional separate bills from physicians who were concerned with the hospital services involved in this care but who had minimal to no personal contact with the patient. The woman would have received two separate personal physicians' bills and, in addition, seven additional professional bills from physicians associated with hospital-based medical specialists. Dr. Snoke goes on to say:

The above illustration of multiple professional bills illustrates the problem that the implementation of S. 1 and H.R. 6675, as currently written, will present. It is almost impossible to outline an understandable procedure by which 9 to 11 separate doctors' bills, ranging from $0.30 to $350, would be presented to one patient in which the patient not only has to decide how to apply the deductible requirement of $50 but also to calculate how much is owed the 11 physicians on the 80- to 20-percent division. If this is confusing to the Senate Finance Committee, multiply this confusion by some 14 million individuals aged 65 or more. Amendment No. 79 would enable hospitals and physicians to continue under present established and satisfactory patterns of reimbursement in this regard.

As I understood the Senator from Utah, he said this should be settled by contractual relationships between a specialist and the hospitals; that is the precise purpose of our amendment, No. 156.

(The statement referred to follows:)

GRACE-NEW HAVEN COMMUNITY HOSPITAL,
New Haven, Conn., May 5, 1965.

HON. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
2227 Senate Office Building,
Washington 25, D.C.

DEAR MR. CHAIRMAN: I appreciate very much the opportunity of submitting a statement to the Senate Finance Committee on S. 1 and H.R. 6675, and particularly on Amendment No. 79 pertaining to the in-hospital services of medical specialists.

I am Dr. Albert W. Snoke, executive director of the Yale-New Haven Hospital of the Yale-New Haven Medical Center, New Haven, Conn. I am also professor of hospital administration in the Department of Epidemiology and Public Health of the Yale University School of Medicine and am a past president of the American Hospital Association. I speak for the New England Hospital Assembly representing the hospitals of the States of Connecticut, Rhode Island, Massachusetts, Maine, Vermont, and New Hampshire, and as an individual who has represented hospitals in dealing with American Medical Association and medical specialties in hospital-physician relationships over the past 15 years.

You will have heard testimony from individuals representing the Department of Health, Education, and Welfare, Labor, Blue Cross, and the American Hospital Association urging that Amendment No. 79 be accepted so as to include the total services of pathology, radiology, physiatry, and anesthesiology in hospital benefits received by the aged. I would also urge that Amendment No. 79 be approved for the following reasons:

1. The provision of efficient and economical hospital and medical care to patients in this country is extremely complex and is growing in complexity daily. It is just as difficult to differentiate precisely between what constitutes nursing care and medical care as it is to differentiate between hosptial care and medical care. Hospital and medical services in such hospital-based medical specialties as radiology, pathology, anesthesiology and physiatry are part of the total health care services provided in a hospital and are in sharp contrast to those medical activities in which an individual doctor acts as a personal physician to an individual patient.

This complexity requires the utmost flexibility in the development of professional and financial relationships so as to permit physicians and hospitals at the local level to establish agreements that will provide the highest quality of care to the patient in the most efficient and economical manner.

This understanding is clearly emphasized in S. 1 and H.R. 6675, title XVIII, section 1801, "Prohibition Against Any Federal Interference" in which it is stated 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."

This is an excellent statement of principle—but is inconsistent with the present text of the bill in which traditional, longstanding, and satisfactory financial and administrative arrangements between hospitals and radiologists, anesthesiologists, pathologists, and physiatrists are arbitrarily and markedly changed. Amendment No. 79 would again permit hospitals and individual physicians to develop their own financial and administrative relationships in the same flexible patern that has obtained in the past and which has resulted in equitable and satisfactory arrangements.

fusion is serious enough for those familiar with hospital and professional billresult from the present bill unless Amendment No. 79 is accepted. One can understand the potential chaos that will result under the existing bill only if one analyzes the actual procedures by which hospitals and physicians would have to operate under the present provisions of the proposed bill. The confusion is serious enough for those familiar with hospital and professional billing—it would be virtually impossible to explain the necessary procedures to many of our elderly patients.

I have taken two patients' bills from the hospital files. The first case is a 79-year-old male with cancer of the prostate gland and with a cardiac complication. The second is a case of a 75-year-old female with a cataract operation but also with a cardiac complication. In both cases, the professional services of many separate individual physicians on the hospital medical staff were involved. The patients also had their own personal physicians.

The following table summarizes the professional fees charged by the personal physicians and also the value of the professional component of the hospital-based medical specialties if separate professional fees based upon costs were to be presented by each of the other physicians:

Individual physicians involved in the hospital care of 2 elderly patients

	79-year-old male, cancer of the prostate gland	76-year-old female, cataract operation
Physicians rendering a bill for personal professional services:		
Surgeon	[1] $350.00	[1] $300.00
Cardiac consultant	[1] 50.00	[1] 50.00
Individual physicians providing professional services through hospital-based medical specialties:		
Anesthetist	[2] 60.00	[2] 27.30
Radiologist	[2] 50.00	
Clinical pathologist, blood bank	[2] 5.00	[2] 3.50
Clinical pathologist, clinical chemistry	[2] 8.00	[2] 3.80
Clinical pathologist, clinical microscopist	[2] 5.00	[2] 3.80
Clinical pathologist, clinical microbiologist	[2] 7.00	[2] 3.70
Pathologist, tissue	[2] 7.50	
Electrocardiologist	[2] 8.00	[2] 5.00
Cardiopulmonary, inhalation therapist	[2] 3.00	[2] 4.00

[1] Actual bills presented to the patient for personal professional services.
[2] Value of professional component of hospital-based medical specialties now covered under hospital bill but for which separate professional bills would needed to be rendered under S. 1 and H.R. 6675.

The man with cancer of the prostate gland would have received two separate bills from the physicians who were directly concerned with him as personal physicians plus nine additional separate bills from physicians who were concerned with professional services involved in his care but who had minimal to no personal contact with the patient.

The woman with the cataract operation would also have received two separate personal physician bills and in addition seven additional professional bills from physicians associated with hospital-based medical specialties.

The above illustration of multiple professional bills illustrates the problem that the implementation of S. 1 and H.R. 6675, as currently written, will present. It is almost impossible to outline an understandable procedure by which 9 to 11 separate doctors' bills, ranging from $0.30 to $350, would be presented to one patient in which the patient not only has to decide how to apply the deductible requirement of $50 but also to calculate how much is owed the 11 physicians on the 80- to 20-percent division. If this is confusing to the Senate Finance Committee, multiply this confusion by some 14 million individuals aged 65 or more. Amendment No. 79 would enable hospitals and physicians to continue under present established and satisfactory patterns of reimbursement in this regard.

3. Unless S. 1 and H.R. 6675 is amended as indicated, the expense to the patient and to the public in general will be substantially increased. Reference to the previous table indicates the costs currently paid by individuals or third parties for the hospital-based professional services received under our present system of reimbursement. It can be categorically predicated that there will be no such individual professional fee charges, especially in the smaller amounts shown in the above table, if submission of individual professional fees is required. The expense of separate billing and collection procedures in addition to minimal professional fee charges will increase the charges and the cost of professional care substantially.

It is important for the committee to recognize the source from which pressure has come for this type of mandatory individual fee billing. It is significant that much of the advocacy of separate billing comes from those individuals who have been opposing the entire concept of the use of social security for providing hospital and medical care to the aged, but now are favoring an isolated component in this bill that would increase professional fee income.

The philosophical objectives of the proposed legislation have been to aid the aged. Its proponents have sincerely advocated relief of hospital and medical expense, improvement in the quality of care and economy of operation and administration. I have personally supported these objectives and so have the great majority of the hospitals in this country. I cannot state too strongly, however, that, without the proposed amendment No. 79 restoring the hospital-based medical specialities to the hospital benefits received by the aged, a much more complicated, cumbersome, and expensive program will result. It will not provide the type of hospital services that the proponents expect or that the aged should get.

The principles and the objectives of S. 1 and H.R. 6675 are to be commended and supported. Give those of us who will have the responsibility of helping to implement this significant and far-reaching program the opportunity of doing it in a sensible and realistic fashion. Amendment No. 79 is imperative if we are to be able to do a satisfactory job.

Sincerely yours,

ALBERT W. SNOKE, M.D.,
Executive Director.

Senator ANDERSON. Thank you very much, Doctor.

I do wish you would remember we gave you 1 hour and 10 minutes of questions and answers and you stayed well within your time limit in the presentation of your paper which I appreciate very much.

Mr. WARD. Thank you very much.

Senator ANDERSON. Dr. Hampton.

I will ask Senator Smathers to introduce you, Doctor.

Dr. HAMPTON. Thank you.

Senator SMATHERS. Members of the committee, I would like to state that, on behalf of the Florida congressional delegation, we welcome the testimony of Dr. Phillip Hampton, from Tampa, Fla., who is one of our most distingished physicians and at the same time one of the most articulate spokesmen with respect to matters involving health care as well as other political matters. We are happy to have him here and I am certain he can make a genuine contribution to our consideration of this legislation.

Dr. HAMPTON. Thank you, Senator Smathers.

Senator ANDERSON. Go ahead, Doctor.

STATEMENT OF DR. H. PHILLIP HAMPTON, PRESIDENT, FLORIDA MEDICAL ASSOCIATION

Dr. HAMPTON. Mr. Chairman, and members of the Committee on Finance, I am H. Phillip Hampton, a physician in the private practice of medicine in Tampa, Fla., president of the Florida Medical Association and, since 1955, chairman of the advisory committee to the State board of health on tax-supported health care.

It has been our objective that no one should go without needed medical care in Florida. During the past fiscal year $50 million of Federal, State, and county funds have been expended in providing health services for needy Florida residents.

Amendments to the present Kerr-Mills law provided in H.R. 6675 will appreciably increase the tax-supported health services available to those in financial need of all ages.

However, administration of the Kerr-Mills programs would be improved if States had authority to designate the appropriate State agency qualified to administer the medical program. The present law and the proposed amendment require that the same State agency ad-

ministering the welfare program must also administer the medical program. We suggest that the word "shall" in paragraph 5 on lines 8 and 13 of page 126 be replaced by the phrase "or other State agency may"——

Senator ANDERSON. Can I break in for a minute?

Dr. HAMPTON. Yes.

Senator ANDERSON. You recognize the Kerr-Mills bill has a recognized fundamental basis of need.

Are the welfare people more qualified to pass on that?

Dr. HAMPTON. We feel the welfare people are qualified, more qualified to pass on need, on the financial eligibility, but they are not qualified to administer medical programs. We do not feel that in many States they are the more appropriate agency best qualified to administer the medical program.

Senator ANDERSON. Thank you.

Dr. HAMPTON. Permitting exercise of this discretion by the State would encourage more efficient and economical operation of the medical program.

We approve those provisions of the voluntary supplemental insurance plan for the aged permitting the administration of this plan by an insurance carrier. In this manner, compensation for medical services would be in accord with well-established third-party payment plans now operating in the private sector of the medical economy and would encourage ministration of physicians services in the least costly abode appropriate to medical need, whether it be in the home, office, nursing home, or hospital. We approve the exclusion of compensation for physicians' diagnostic or therapeutic services from the basic hospital insurance trust fund, for it will reduce the practice of hospitalization for simple diagnostic procedures and thus effect an appreciable saving in expenditures from the social security tax-supported fund.

Essential for the success of any medical care plan is the support and earnest desire of practicing physicians to make it work. Good modern medical care requires the cooperative effort of physicians. Efficient and economical medical care can be achieved only through the willing cooperation of physicians in the practice of medicine and in continuing medical education. A minor amendment to the voluntary supplemental insurance plan may encourage physician support and provide the vehicle for their cooperative fulfillment of medical administrative and educational responsibilities.

A fund for medical education, administration and research could be created through voluntary contributions by physicians of a portion of his payments from the supplemental insurance plan. Such contributions would be encouraged if the physician were permitted to voluntarily instruct the carrier to deposit $3 into a pension fund for himself for each dollar he contributed to the education fund provided the amount deposited to the education fund and to the pension fund were deferred as taxable income to the physician until actually paid for services or pension.

This would be accomplished by the following amendments on page 66 to section 1842(b)(3)(F)—the carrier—will pay into an approved fund for medical eduction, administration, and research, when authorized by the physician provider of the service, payments due a physician for services rendered under provisions of this program, including

services rendered with the assistance of interns and residents in an accredited training program.

Any contract with a carrier may authorize the carrier to establish a pension plan for physician providers of services under provisions of this program to which the physician may voluntarily authorize deposit of some of the payments due him for medical services rendered.

Funds deposited by the carrier into an approved fund for medical education and research or pension plan at the voluntary direction of the physician provider of services shall not be considered taxable income until paid for services or pension, except that payments deposited into the pension fund may not be more than $3,000 annually for each individual and not more than three times the amount of payments deposited into approved education and research funds.

In this manner private funds voluntarily contributed by physicians and administered by the medical profession at State and local levels could promote the cooperative effort of physicians in fulfilling traditional medical responsibilities in continuing education and medical administration essential to the economical provision of good, modern medical care.

It would also help to provide pension opportunities for physicians similar to those available to business executives. Deferred income is more suitable to the needs of elderly physicians than social security payments and we hope social security coverage for physicians may be optional.

Although we oppose the principle of Government obligation to provide personal services as a right of citizenship and regardless of financial need as established by part A of title XVIII, Hospital Insurance Benefits for the Aged, these opinions have been expressed previously.

Thank you for the opportunity of presenting our views concerning the medical care plan (H.R. 6675.) We think these constructive suggestions will improve the efficiency and economy of operation and encourage the cooperation fo physicians in achieving the highest quality medical care for the recipients.

Senator ANDERSON. Thank you, Doctor.

At least that is a very interesting proposal and we are glad to have it.

Senator Williams?

Senator Smathers?

Senator SMATHERS. Doctor, a couple of questions.

First, as I understand what you are saying, you wish to see this bill amended so that the administration of the health care plan operating under the presumption that the bill is going to be passed, would be administered by a State agency or could be administered by a State agency other than the welfare department; is that correct?

Dr. HAMPTON. Yes, sir. It would be at the option of the State.

Senator SMATHERS. At the option of the State.

Would that require legislative action in the State legislature in order to accomplish that which you are talking about?

Dr. HAMPTON. Yes, sir. Each State would have to express their preference.

Senator SMATHERS. I wonder if you could elucidate for us just a bit as to why you do not feel that the welfare department of a State

which today administers the Kerr-Mills law, and we have the Kerr-Mills law in our State, why you think they should not be the agency to administer the health service part of the social security bill?

Dr. HAMPTON. The welfare department is oriented toward welfare, and these are medical problems that require quite a different point of view. They have not been cooperative in expanding the Kerr-Mills program in Florida to the extent that we, as physicians, would have liked to have seen it expanded. They have through regulations impaired the application of the basic principles of providing health services for those in need, and indeed the appropriation in Florida for the medical assistance for the aged program, has been only half used, not because there was no need for it to be used but because of restrictive regulations imposed by the State welfare department which have drastically limited the eligibility requirements and have limited services that we, as physicians, have recognized should be offered and have urged that they be offered and the State law permits them to be offered.

But the department of public welfare has through regulations retarded, thwarted the efforts of the State and the Federal Government and of the physicians in implementing this program.

This is not true in all of the States.

Senator SMATHERS. For example, what agency do you think could be created or would be selected in Florida to administer the health services part of this social security bill?

Dr. HAMPTON. We feel perhaps the State board of public health could be a more appropriate agency, and indeed, in Florida, the law permits the State welfare department to make a contract with the State board of health to administer the medical care part of the program.

But this is a contract for the fiscal administration. It allows no opportunity for the State board of health to make any administrative regulations or decisions or control over the program at all.

So, that this is really just a fiscal arrangement that is not helpful, and the language in the present law and in the amendments proposed by H.R. 6675, would still be restrictive on the States and require that the administration and decisions for administration of the medical care program must be by the same State agency administering the welfare program.

Senator SMATHERS. Now, all you are then seeking, as I understand it, is an amendment to this bill which would give to each State the right to determine which State agency in their judgment would be most effective in the administration of this health care and health services under the social security bill.

Dr. HAMPTON. Yes, sir; that is true. It is my understanding that members of the House Ways and Means Committee were given the information that this present law, H.R. 6675, did just that, give the States the latitude, and I have a letter from one of the members stating that he was assured before he voted on that measure that this law provided the States the latitude to appoint the appropriate State agency to administer the medical care program but he then quoted the law which, of course, is just the opposite.

Senator DOUGLAS. Will the Senator yield?

Senator SMATHERS. Yes.

Senator DOUGLAS. Are you speaking, Doctor, of the third layer of the cake, the expanded Kerr-Mills plan, or the second layer, the supplemental medical and surgical benefits, or the basic hospital and nursing care?

Dr. HAMPTON. Senator Douglas, I am speaking of the Kerr-Mills part of the program, the third layer.

Senator DOUGLAS. You don't quarrel with the administration of hospital and nursing care although you are apposed to it, granted it is coming, I mean.

Dr. HAMPTON. The discussion we have just had now——

Senator DOUGLAS. Applies entirely to Kerr-Mills.

Dr. HAMPTON. Kerr-Mills.

Senator DOUGLAS. Thank you.

Senator SMATHERS. Fine, that is a good point, and I am glad the Senator brought it up.

Senator ANDERSON. Was there any explanation of how this member of the Ways and Means Committee was misled, was he deliberately misled or what was the situation?

Dr. HAMPTON. I just have his letter which I have given to Senator Smathers, and he stated—

I was advised that it was that broad—

And then—

In the final bill which was approved yesterday the wording is as follows—

And he quotes from the bill, paragraph 5 on page 126, which says definitely that the same State agency must administer the medical program as well as the welfare.

Senator ANDERSON. Thank you.

Senator SMATHERS. All right.

Now, Doctor, moving to another area, in your testimony you talk about a fund for medical education, administration, and research.

Was this matter presented to the House Ways and Means Committee? Was this recommendation providing for voluntary contributions by physicians of a portion of his payment from the supplemental insurance plan, and so on presented to the House Ways and Means Committee?

Dr. HAMPTON. No, sir; that was not presented. We did not have an opportunity because they did not have hearings on the supplemental insurance plan portion.

Senator SMATHERS. I wonder if you would run that by me again, as the late Senator Kerr used to say, for a better observation and understanding of it.

I am not certain I know what you are driving at.

Dr. HAMPTON. Traditionally physicians have felt responsible to promote, encourage, and participate in graduate medical education, and they have responsibilities in administration of medical affairs, in hospitals, for instance, as graduate medical education directors, chiefs of services.

As a matter of fact, we are speaking here in the total bill, H.R. 6675 of many administrative responsibilities that physicians must assume, and they must assume them if there is going to be economical and efficient administration of this program.

I am trying to provide here a fund (we have been trying to provide it in Florida for a number of years and in effect we have a fund

but we are lacking in funds) that physicians can create themselves voluntarily and administer themselves; a vehicle to fulfill these traditional responsibilities in administration and in medical education, and I think that if such a fund could be created, the country, the patients would get far more service out of each dollar spent through that fund then they could through any moneys appropriated by Government agencies or otherwise.

Senator SMATHERS. What you ask, as I understand it, is that this contribution made to the fund by the doctors be considered as tax deductible?

Dr. HAMPTON. Yes, sir.

Senator SMATHERS. That is the point you are after?

Dr. HAMPTON. As a further incentive to create the fund. They could do it now and I think it would be enlightened self-interest for the physicians and certainly in the interests of good medical care for the whole country, but I think we need a little more incentive.

Senator SMATHERS. Would these doctors go back to school, or what would they do under this fund? What use would be made of the fund?

Dr. HAMPTON. Well, a great part of a medical education now is outside medical schools, in hospitals, particularly, and, of course, this is for interns and residents, medical students who have just finished medical school, but it is just as important, if not more important, for continuing medical education for practicing physicians who participate in these programs. This would be, in my opinion, far more effective in closing the gap between new discoveries in medicine by research and the practice of medicine by physicians than would be accomplished by Government appropriated and administered funds, practicing physician.

This little fund created by doctors themselves could do a far better job than the large expenditure of funds envisioned under the program to create regional medical centers for cancer, stroke, and heart disease.

Senator SMATHERS. Doctor, on another point, are the doctors of Florida interested in seeing the Congress give additional consideration to the establishment of private pension funds, so to speak, similar to bills which we have had heretofore, one which has been called the Herlong-Smathers-Keogh bill or one time the Keogh-Herlong bill?

You know what I am talking about, private pension plans.

Dr. HAMPTON. Yes, sir; I do.

The doctors have expressed, in polls and through the house of delegates, great interest in such funds as tax-deferred funds for pensions that they may create for themselves through the legislative mechanism that you have mentioned. They have a far greater interest and approval of that type of pension plan than they have expressed for social security.

Senator SMATHERS. Two more questions. Is it your judgment that the majority of the doctors of Florida desire to be covered under social security?

Dr. HAMPTON. It is my judgment that the poll we sent out, Senator, was a little confused because it included two questions.

Would they prefer the Herlong-Smathers-Keogh approach or the social security approach?

In the aggregate, of course, the pension plan, Herlong-Smathers-Keogh approach was by far approved. But there was no clear-cut ma-

jority on the simple question of whether or not they would approve coverage under social security. They said they would far rather approve the other but then the question of if it were not available what would they want to do, I am afraid I cannot give you a clear-cut answer.

Senator SMATHERS. All right.

Is it your judgment that the majority of the physicians of Florida expect this time this year, 1965, that the social security program will be broadened to include health services and that they are reconciled to that fact and would cooperate and work within the provisions of such a law?

Dr. HAMPTON. I am sure the majority of physicians of Florida will cooperate to provide the best medical care they can under any circumstances. They have their opinions as to how it can be better done, what legislative mechanisms would help, and they do not approve of providing tax supported health services for those citizens who can afford to pay for themselves. They feel that this is not only an imposition on the taxpayer but it establishes a new principle of government, an obligation on the Federal Government to provide personal services as the right of citizens regardless of need. This opens the Pandora's box and establishes the keystone for personal services of all kinds that could be provided by the Federal Government regardless of financial need.

Senator SMATHERS. All right.

Thank you very much, Doctor.

Senator ANDERSON. Senator Dirksen?

Senator DIRKSEN. I have no questions.

Senator ANDERSON. Thank you very much, Doctor, for being here.

The next witness is Dr. Siegel, of the Illinois State Medical Society.

Senator Dirksen, if you will please introduce Dr. Siegel, when he is ready to start testifying.

Senator DIRKSEN. Mr. Chairman, Dr. Siegel is from East St. Louis, Ill., and he has been chairman of the legislative committee of the Illinois Medical Society.

This society has somewhat in excess of 10,000 physicians and surgeons, who are active members of the society. Incidentally, Mr. Chairman, before Dr. Siegel proceeds, I noted the discussion here with respect to the benefits available under Kerr-Mills.

In the State of Illinois we have established the means test by means of level of income and property held. The individual can have an income of $1,800 or in the case of a couple they can have an income of $2,400 a year and still be eligible for Kerr-Mills payments.

In addition to the income, and I am drawing on memory now, an individual or a couple can also own a home and in addition to that can own an additional $2,800 worth of property, and still have available or still have the benefits of Kerr-Mills.

The State has been very generous, and I think in the initial program for the first biennium through our legislature expended $18 million.

Dr. SIEGEL. $20 million.

Senator DIRKSEN. It was in that neighborhood and I kept abreast of it from time to time to see how it operates but I must say so all the world can hear that we have been very generous, we have been very generous in order to make the Kerr-Mills bill work and I am

sorry to say that the Department of Health, Education, and Welfare has not been very helpful in encouraging the State.

When we discussed this matter a year ago I asked Secretary Celebrezze for information that had gone out to the average person over 65 who might be available. They had virtually no literature put out.

What they sent out were directions for the local office and I know one of my staff called up at HEW to get some information on Kerr-Mills and when the operator at the other end of the line asked what he wanted to know and he wanted information on Kerr-Mills and just like that she said, "You know it isn't working, don't you?"

So, when you can't get by the telephone operator, how do you expect to get by the Secretary who runs the Department?

I wanted to make it clear what we have done in Illinois under Kerr-Mills.

Doctor, I may not be able to hear you out because we have to leave when the session begins.

STATEMENT OF DR. V. P. SIEGEL, CHAIRMAN, LEGISLATIVE COMMITTEE, ILLINOIS STATE MEDICAL SOCIETY

Dr. SIEGEL. Sure.

Mr. Chairman and members of the committee, I am Dr. V. P. Siegel, East St. Louis, Ill., practicing surgeon and chairman of the legislative committee of the Illinois State Medical Society. I appear before you today on behalf of the society, representing approximately 10,000 practicing physicians in the State of Illinois.

Accompanying me, available to answer questions, is Dr. Norris L. Brookens, chairman of the society's committee on economics and insurance. Dr. Brookens is a practicing internist at the Carle Clinic in Urbana, Ill.

We are concerned with the magnitude of the changes in health care services which will be brought about by the enactment of H.R. 6675. We deplore the speed with which this legislation has been rushed through the House. We commend the Senate Finance Committee for recognizing the need to examine the provisions of the bill in open hearings.

SUPPORT OF AMA

Dr. Donovan F. Ward, president of the American Medical Association, has presented a statement outlining the views of the majority of American physicians. This statement evaluates H.R. 6675 in depth and offers numerous recommendations. We wish to be placed on record as supporting the AMA recommendations. We wish, however, to amplify four key points in the testimony with respect to H.R. 6675 as it is now written:

(1) Removal of physicians from mandatory social security coverage;

(2) Physician specialty services;

(3) Use of the term "reasonable" in conjunction with charges; and

(4) Medically oriented administration.

SOCIAL SECURITY COVERAGE

It is generally known and agreed that physicians do not retire at or near age 65 and that it is not in the public interest to encourage them to do so. There is no justification for forcing physicians to participate in a program from which they will derive, at the most, only limited benefits. Social security is a taxing program to pay current benefit obligations. It is not insurance. Nevertheless it relates to benefits reasonably anticipated at some future date. Only 1 year ago your committee removed physicians from mandatory coverage under H.R. 11865 and indicated that it would not compel us to become a part of the old-age, survivors, and disability insurance program until the majority of physicians wished to be covered.

The official position of the Illinois State Medical Society was established by a survey authorized by our house of delegates in 1961. The survey showed that 54 percent of the physicians who responded were opposed to compulsory coverage. The results were published in the December 1961, Illinois Medical Journal. A copy of the article is appended. [Incorporated in committee files.] We support the AMA statement that the majority of physicians do not want social security coverage.

SPECIALTY SERVICES

Approximately 1,200 physicians in Illinois practice in four specialties—anesthesiology, radiology, pathology, and physiatry. While these services are largely performed in the hospital setting, they are medical services provided by physicians and should be treated accordingly.

The framers of H.R. 6675 very wisely reasoned that the physicians of this country would not willingly accept a program which permits their services to be disposed of at the discretion of hospital administrators. This has been a subject of much concern among these specialties over the years.

The problem has been largely resolved in anesthesiology by the adoption of direct patent billing. We support the position of the four specialties as taken by their organizations and urge this committee to retain these specialty services under part B.

"REASONABLE" CHARGES

The term "reasonable charges" is used at several points in the bill to describe the amount which the Government will pay for services rendered by individual practitioners under part B of the medical care program. Charges or fees are the amounts established by individual practitioners and their patients to value physician services in the marketplace. Charges vary widely according to the skill and demand for the services of the physician.

We do not believe it is the intent of Government to establish a nationwide physician's fee schedule or to infer that certain medical fees are not "reasonable" simply because they do not conform to the proposed payment schedule. We recommend that the word "customary" be substituted for the word "reasonable" as applied in this section of the bill.

MEDICALLY ORIENTED ADMINISTRATION

It is of major concern, to medical societies and is continually expressed by our individual members, that the administration of health care programs cannot be successful when physicians are not adequately consulted. We recommend that acceptable medically oriented administrative agencies be clearly defined in the final legislation.

This talent is already available in many State and county health departments, cooperating, and I emphasize that, with State and county medical societies.

Since H.R. 6675 is stated to be a medical care program, not a welfare program——

Senator SMATHERS. Is that what was said by the doctor who preceded you, Dr. Hampton?

Dr. SIEGEL. It is the same. We would like to get the type of administration that would get the most cooperation.

Since H.R. 6675 is stated to be a medical program, not a welfare program, it will require high caliber, well-trained, competent medical direction.

This seems to be partially recognized in H.R. 6675 although the language is extremely vague. Section 1816, presumably would allow part A, to be administered through any public or private agency acting as the fiscal administrator.

Section 1864, specifies that State health departments may be used to determine compliance by providers of service with conditions of participation but it also implies that other State agencies may be used.

NEED NOT AGE

In our remaining time we will discuss the overall health care portion of this bill in relation to the practical experience of our members in dealing with Government medical care programs.

Our experience in this field convinces us that any program to provide health care with public funds should be related directly to financial and medical need, not to a single-age factor—and further that such a plan must be responsive to local situations and needs through local administration—and, finally, that existing prepayment and insurance plans should be supplemented not supplanted.

We believe this bill will result in chaotic conditions in the administration of benefits when a large segment of our population is in a position to demand these benefits as a matter of right.

Most physicians in practice have received part of their training in public tax-supported hospitals. We became familiar with what is called APA. This is the medical jargon for acute political admission. We learned the facts of life in regard to chronic political retention of patients in the hospital.

When hospital services are made available as a matter of right these problems will increase due to political pressures. The medical utilization committees provided for in H.R. 6675 cannot be expected to cope with the acute political admission and retention.

Hospital utilization committees are not new. They have been useful but the problems are enormous even without the injections of political considerations on medical judgments. Many who have worked on

such committees believe the most effective utilization control results from long hospital waiting lists.

Gentlemen, when this happens—and it will almost immediately—not only the doctor, but the Congress will receive repeated telephone calls. This will be followed by rule—we believe—upon rule, issued by the Secretary of Health, Education, and Welfare.

Illinois physicians have a proud and productive heritage of cooperation with public agencies which provide care to those who have a real need for governmental assistance. Through a system of State and county medical advisory committees, we assist the administration of the quality, quantity, and cost standards of our public aid medical program. A fee schedule is utilized which in many instances is below the actual out-of-pocket cost of the physicians' services. Many patients are cared for without charge to avoid excess paperwork.

It is not an easy task for any professional group to sit in judgment on the performance of its members when proper incentives do not exist. When the need factor is removed, what incentives remain for the physician to voluntarily conserve public funds? If the payment for medical care for all elderly, regardless of need, becomes the responsibility of the Federal Government, the incentives are removed for physicians to service public aid patients under title XIX at less than their customary fee or at no fee.

We urge the committee to evaluate these and many other practical considerations before establishing any federalized health care program such as is proposed under H.R. 6675.

We conclude our testimony by asking you to replace the health care portions of H.R. 6675 with a program which relates to financial and medical need rather than age. We recommend a program which would be administered by the States and utilize the tested methods of private insuring organizations.

Gentlemen, we sincerely appreciate this opportunity to appear before you to state our views.

Senator ANDERSON. Thank you very much.

Senator Dirksen, do you have any questions?

Senator DIRKSEN. I have no questions.

Senator SMATHERS. I have no questions.

Senator ANDERSON. Thank you very much, Doctor, and I appreciate the brevity of your statement. It is well done but still brief.

Thank you.

Dr. SIEGEL. Thank you.

Senator ANDERSON. I am going to call on Dr. Teall next.

Dr. Chenault—are you Dr.——

Dr. TEALL. I am Dr. Teall.

Senator ANDERSON. I am skipping you, Dr. Chenault, because Senator Sparkman wanted to be here.

STATEMENT OF DR. RALPH TEALL, PRESIDENT, CALIFORNIA MEDICAL ASSOCIATION

Dr. TEALL. Mr. Chairman and Senator Smathers, you have a copy of my oral testimony proposed, and I will cut this quite short since it is available to you.

Senator ANDERSON. I promise you I will read it as I have the whole statement of the AMA.

Dr. TEALL. And you and I are the whole committee.

Senator ANDERSON. We are now.

Dr. TEALL. You have a copy of my testimony and the supplemental statement, and I only want to make one or two points.

I am a physician in practice. I am president of the California Medical Association, and I do represent the views of approximately 22,000 doctors there.

We are concerned about two elements in the proposed H.R. 6675, A and B in title XIX, and our comments on this, in general, parallel the comments already made by the physicians here today.

We would like to request, if at all possible, that the supplementary insurance health benefits to the aged be dropped from the consideration of the committee at this time, and considered in a separate bill so that its merits will not be confused with the many portions of H.R. 6675, but there are many portions of 6675 we are delighted to support, and we indicated our support in California.

We are concerned that the matter of need remain in any legislation that is enacted, and that there shall be a rewriting of parts A and B, if possible, to introduce or to reincorporate the original concept of health care related to need.

Yesterday, sir, you commented on the relationship between social security payments and the problem of medical care, as if there were some parallel to be drawn. I would like resepectfully to suggest that the social security payments are designed to be a floor and are just exactly that, a very minimal floor. It is our understanding that $100 to $125 is essentially the maximum monthly return for an individual and cannot be regarded as in any way an adequate standard of living for citizens in our State.

However, in regard to medical care, where any help is to be given, it is highly desirable that it include all of the medical care required. It is important that the patient stay in the mainstream of medical care in the community, and he should be subject to no discrimination and no segregation from other citizens who are able to provide for their own care.

We are also aware of the historical development of your King-Anderson bill and the reasons why, as a result of this development, hospitalization has been given high priority in H.R. 6675.

Primary emphasis has been placed there as to the basis of all medical care, but it is recommended that these medical care insurance programs, if enacted, be recognized to emphasize and support office, home, and outpatient care as the basis of good medical care rather than hospital care.

We believe that in many instances, the intent of the Ways and Means Committee of the House as expressed in the House report has not been included in the bill, we have listed in our formal statement some specific suggestions we believe might clarify the intent in the specific language of the bill.

The only point on which I would like to comment specifically is the intent of the committee, as stated in its report, that in determining reasonable charges of physicians the carriers would consider the customary charges for similar services generally made by the physician, and the prevailing charges in the locality. These phrases do

not appear in the bill, and we would suggest they be restored in the bill in the appropriate place.

As has already been testified by many witnesses before you, we in California believe that inpatient hospital services under either of the proposed health insurance benefit programs should continue as in the House-passed bill to exclude physicians' services. Unlike the comments made yesterday by Senator Douglas, however, we do not believe that a reintroduction of these so-called specialist services under the hospital insurance portion of the bill is confirming the present practice of medicine.

In California, at least, which is the only area with which I am privileged to speak, the present practice of medicine and the present developments are quite the opposite particularly as regards anesthesiologists, physiatrists, and X-ray persons. These people are not now, in many instances, being billed on their hospital services, and there is an increasing tendency for them to bill for professional services independently.

We believe the amendment proposed by Senator Douglas, therefore, is in opposite direction to the present developments in the practice of medicine.

An additional point we would like to call to your attention is that if the specialists' services are placed under the hospital insurance plan, we will be under increasing pressure, as testified by previous witnesses, to admit people to the hospital in order to get these specialty services paid for under the bill. We believe that it would be much more economical if these services were left on the outpatient basis where most X-ray and, as you indicated yesterday, most laboratory services are actually provided.

It would diminish the pressure for hospitalization and, therefore, the expense under that portion of the bill in order to obtain these services.

In summary on that issue, sir, we believe that the present practice in California is to separate these services from hospitals. We are in contact with California Hospital Association. The California Hospital Association is quite sympathetic with our point of view, and only yesterday informed me that they would like it read into the statement that in their belief, the primary orientation of the practice of medicine is the physician wherever he may work, both in or out of hospital practice.

Senator ANDERSON. Doctor, that differs somewhat from the position of the American Hospital Association.

Dr. TEALL. Yes, sir; I recognize this. I am informed that the California Hospital Association is supporting the American Hospital Association regarding radiologists and pathologists at this time; they are perefectly happy in discussing with us and their own board of directors whether this could not be resolved on the basis of a time interval in order that the billing procedure of the hospitals could be worked out. It is my impression they feel not quite so strongly as the American Hospital Association.

I would like to testify here that the relations in California between California Hospital Association and California Medical Association are very, very good. We work problems out together, and we are happy that we can have a continuing fine relationship with that orga-

nization. It has been an increasingly good relationship in the past few years.

This, in general, concludes the comments that I would like to highlight from our proposed oral testimony, except to remind you, sir, that regardless of what changes may be made, the primary point of reference which we would like to emphasize is that the doctors still retain the obligation and the responsibility of finding out what the conditions of any program are, not this one, but any program, under which he takes care of his patients. The doctor, obviously under this bill, has the privilege of deciding for himself in the case of each patient whether the program does enable him to give the highest quality of medical care that he is capable of giving.

The traditional costs in American medical practice are for each physician to do the very highest quality practice he knows, and to find whatever circumstances help him toward this end.

We are, of course, in ideological conformity with the testimony already offered many times by physicians; and the California Medical Association would like to record its belief that the interests of the American public and the patients, who are our patients and our interest, will be much better served if neither the basic hospital benefits program nor the supplemental health benefits program as proposed for the aged by part I of this bill is enacted.

We also would like to subscribe to the testimony already given urging continuation of the present exception from self-employment coverage for services performed as doctors of medicine.

We thank you for the opportunity of making these comments in the record.

(The prepared testimony of Dr. Teall follows:)

TESTIMONY ON H.R. 6675 BY RALPH C. TEALL, M.D., ON BEHALF OF THE CALIFORNIA MEDICAL ASSOCIATION

Senator Byrd, members of the committee, my name is Ralph Teall. I am a doctor of medicine. I have conducted a private practice of medicine and surgery in the city of Sacramento, Calif., since 1932. I am the president of the California Medical Association, a voluntary association of over 22,000 physicians.

Our entire concern in studying the text and effects of H.R. 6675 is to maintain and improve the highest possible quality of medical care for each American citizen and its full availability when needed.

The physicians of California are pleased to support the proposals for extension and improvement of Federal grants to States for medical assistance programs (the proposed new title XIX of the Social Security Act). I have just completed testimony before a committee of the California Legislature proposing extension of our State public medical assistance programs to conform to this new title XIX, utilizing prepayment plans to protect the dignity of the patient, to keep public assistance beneficiaries in the mainstream of medical care, to simplify Government administrative procedure and save the money of the taxpayers.

There is, however, very serious question with regard to the appropriate role of Federal Government in the problems of financing medical care for the aged who are not needy.

It is obvious that a tax-supported system which completely disregards the financial need of the beneficiary contains a built-in demand for limitless extension and expansion. Prudence would suggest a program which contains a concept of built-in decrease as need decreases. This concept is inherent in relating the Government's support to a workable definition of "need."

It is suggested that the subject matter of part 1 of title I—health insurance benefits for the aged—be separated from H.R. 6675 and be considered independently.

It is further suggested that the supplementary health insurance benefits for the aged be dropped entirely from legislative consideration.

If this is not acceptable, and you choose to recommend either the basic hospital, or the supplementary health insurance benefit plans, it is recommended that each be rewritten to incorporate the concept of help related to need.

Where help is to be given, it is desirable that it include all the help needed for all the medical care required. It is important that the patient stay in the mainstream of medical care in his community. He should be subject to no discrimination or segregation from other citizens who are able to provide for their own care.

Since 1960, a program of medical care insurance with Government paying part or all of the premium cost for nearly 6 million active and retired Federal employees has proven very successful.

It is recommended that the two health care benefit insurance programs for the aged, if they be enacted, be modified to model them after the existing Federal employees' health benefits program.

Under H.R. 6675, primary emphasis is placed on hospitalization as the basis of all medical care. It is recommended that these medical care insurance programs, if they are to be enacted, be reorganized to emphasize and to support office, home, and outpatient care on the basis of anticipated need.

It is suggested that the bill be amended to substitute the phrase "institutional, nonphysician providers of service" wherever the phrase "providers of service" occurs.

Section 1802 of H.R. 6675 guarantees free choice by the patient of "any * * * person qualified to participate * * * if such * * * person undertakes to provide * * * such services." This guarantee is meaningless unless conditions of participation are such that a great majority of physicians voluntarily "undertake to provide" services under the programs.

In several instances the intent of the Ways and Means Committee of the House is not reflected in the bill.

1. The committee report states that "your committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine the length of stay." However, these words and phrases do not appear in the bill. The intent of the committee could be better implemented if the phrases were included.

2. If the determination of what is a "reasonable charge" for physicians' services is to be made by a carrier organization, this should be done only by organizations nominated by the physicians themselves.

It is suggested that the bill be amended by adding a phrase to permit physicians to nominate the carrier organization to represent them such as is done for institutional, nonphysician providers of service.

3. The intent of the committee, that, "indetermining reasonable charges" of physicians, "the carriers would consider the customary charges for similar services generally made by the physician" and "the prevailing charges in the locality," does not appear anywhere in the bill. There should be full recognition of geographic variation as well as local custom and flexibility. It is suggested that the bill be amended by adding the phrase from the report.

We urge that all inpatient hospital services under either of the proposed health insurance benefit programs continue to exclude all physicians' services.

If part I of H.R. 6675 be adopted into law, it is suggested that administration of benefits for physicians' services make greater use of county and State medical associations: (a) in review of claims, (b) in appraisal and control of quality, (c) in supervision and monitoring of utilization for both outpatient and inpatient care, (d) in mediation of misunderstandings and complaints and (e) in establishing the level of "reasonable charges."

The supplementary health insurance plan for the aged is described as "voluntary." There is nothing "voluntary" about general taxation which provides the matching $3 per month. It is anticipated that from 80 to 95 percent of all U.S. residents age 65 or older will enroll. The effect is to eliminate any—and all—other types of health insurance for this age group. The elimination of all voluntary alternatives makes the programs a national compulsory system for the aged. It creates a completely nationalized health insurance system—which will quickly produce a completely nationalized medical care system.

If you should decide to recommend enactment, we have offered some constructive suggestions for changes.

Under any program, the responsibility remains with each individual American physician to decide, in each instance, whether conditions of the program will permit him to provide his highest quality of professional care to the patient.

After very careful and thoughtful study, the physicians of California believe that the national public interest will be best served if neither the basic hospital benefits program nor the supplemental health benefits program, as proposed for the aged by part 1 of H.R. 6675, is enacted.

We urge continuation of the present exception from self-employment coverage for services performed as a doctor of medicine.

Thank you for your courtesy in permitting me to present these views of the California Medical Association.

SUPPLEMENTARY STATEMENT ON H.R. 6675 BY RALPH C. TEALL, M.D., ON BEHALF OF THE CALIFORNIA MEDICAL ASSOCIATION

Senator Byrd, members of the committee: My name is Ralph Teall. I am a doctor of medicine. I have conducted a private practice of medicine and surgery in the city of Sacramento, Calif., since 1932. I am the president of the California Medical Association, a voluntary association of over 22,000 physicians.

Our entire concern in studying the text and effects of H.R. 6675, is to maintain and improve the highest possible quality of medical care for each American citizen and its full availability when needed. We do not view the problems of medical care as political problems. We offer this testimony as a public service based on intimate day by day experience and contact with the problems of sick and injured persons.

The physicians of California are pleased to support the proposals for extension and improvement of Federal grants to States for medical assistance programs as proposed in part 2 of title I of H.R. 6675 (the proposed new title XIX of the Social Security Act). I have just completed testimony before a committee of the California Legislature proposing extension of our State public medical assistance programs to conform to this new title XIX, utilizing prepayment plans to protect the dignity of the patient, to keep public assistance beneficiaries in the mainstream of medical care, to simplify Government administrative procedure and save the money of the taxpayers.

There is, however, a very serious question with regard to the appropriate role of Federal Government in the problems of financing medical care for the aged who are not needy.

H.R. 6675 recognizes the importance of arrangements which will "enable" needy "individuals" to "attain or retain independence or self-care." Any Federal help in financing health care should be based on this self-limiting principle, for greatest service to its beneficiaries and to our free society.

It is obvious that a tax-supported system which completely disregards the financial need of the beneficiary contains a built-in demand for limitless extension and expansion. Prudence would suggest a program which contains a concept of built-in decrease as need decreases. This concept is inherent in relating the Government's support to a workable, nondemeaning, noncharity definition of the "need" of the individual.

The Ways and Means Committee of the House of Representatives has concluded that "Federal Government action should not be limited to measures that assist the aged only after they have become needy" (report No. 213, pp. 20, par. 4). However, even though there may be a general agreement on trying to prevent costs of needed medical care from reducing any elderly citizen to poverty, this is not equivalent to the provision of a monolithic, nationalized medical care insurance system, as is now proposed for all aged, regardless of their level of affluence or of need.

In its present form H.R. 6675 is a huge "omnibus," combining so many different proposals in one bill that none of them can be adequately considered on its own merits. A great many of them are good. Others give rise to serious questions.

It is suggested that the subject matter of part 1 of title I, health insurance benefits for the aged, be separated from H.R. 6675 and be considered independently.

It is further suggested that the supplementary health insurance benefits for the aged, part B of proposed new title XVIII, be dropped entirely from legislative consideration.

If this is not acceptable, and you choose to recommend either the basic hospital, or the supplementary health insurance, benefit plans for enactment, it is recommended that each be rewritten to incorporate the concept of help related to need under a liberal definition of "need."

Where help is to be given in financing medical care, it is highly desirable that it include all the help needed for all the medical care required, rather than a limited fraction of that care. It is important that the patient stay in the mainstream of medical care in his community. He should be subject to no discrimination or segregation from other citizens who are able to provide for their own care. He should be able to use the same facilities and the same kind of insurance support as is used by other citizens. His care and financial support should be arranged in such a way as to permit him to attain or regain his independence and his future self-care at the earliest possible time. These goals are met best by the widely accepted pattern of providing financial help for medical care in the United States through our very successful, and very rapidly growing, voluntary health insurance systems.

One of these systems has been found to work very successfully and economically in public medical assistance programs in the California County of Santa Barbara. A résumé of that experience is submitted to you herewith. The California legislature is now considering extension of that concept to all public assistance medical care as authorized under the proposed new title XIX.

The use of insurance carriers as limited fiscal agents or fiscal administrators has been tried and has been much less successful.

Since 1960, a program of medical care insurance with Government paying part or all of the premium cost for nearly 6 million active and retired Federal employees has proven very successful. This offers freedom of choice of the type or extent of the insurance support desired by the enrolled person in relation to his income, resources, available local facilities, and his medical need. The program has encouraged, supported, and extended the usefulness of the voluntary health insurance systems. It is proving very satisfactory and acceptable to the enrollees, to hospitals, to physicians and other members of the health care team, and to the Federal Government as an employer. A very similar program for active and retired employees of the State of California is working very well. Such programs secure optimum use of voluntary health insurance agencies as full insurance underwriters rather than as limited fiscal agent-administrators.

Under this concept, contributions are made by the beneficiaries as well as the Government. Provision can be made—and easily administered—for the carriers to offer additional benefits which could be purchased by those beneficiaries who desired to do so. The carriers' well-established historic experience can be fully used. The Federal Government will not be directly in the health insurance business with responsibility to reimburse for all or part of the medical care cost of each person age 65 or older. The Federal Government under such a plan supports and encourages medical care insurance coverage. It is, therefore, recommended that the two health care benefit insurance programs for the aged, proposed by part 1 of H.R. 6675, if they be enacted into law, be modified to model them after the existing Federal employees' health benefits program and the retired Federal employees health benefits program.

Under the health care insurance proposals of H.R. 6675, primary emphasis is placed on hospitalization as the basis of all medical care. It is true that hoshospitalization is only an incident in the continuing care, but, for most persons, hospitalization is only an incident in the continuin gcare required. It is far less important than adequate preventive and early diagnostic and corrective care before hospitalization is required. These can often avoid the need for any hospitalization. The overemphasis on hospital care in H.R. 6675 will create a very heavy increase in demand for hospital use, greatly overtaxing the capacity of American hospitals for the present or foreseeable future, and greatly increasing the overall cost of medical care in this country. It is recommended that these medical care insurance programs, if they are to be enacted, be reorganized to emphasize and to support office, home and outpatient care on the basis of anticipated need.

Throughout the bill, frequent reference is made to "provider of service," meaning institutions and not physicians. The items are well defined in this bill. However, most physicians also regard themselves as "providers of service" and the term becomes very confusing. It is suggested that the bill be amended to substitute the phrase "institutional, nonphysician providers of service" wherever the phrase "providers of service" occurs.

Section 1802 of H.R. 6675 guarantees free choice by the patient of "any * * * person qualified to participate * * * if such * * * person undertakes to provide * * * such services." This guarantee is meaningless to the patient unless conditions of participation are such that a great majority of physicians voluntarily "undertake to provide" services under the programs.

In several instances the intent of the Ways and Means Committee of the U.S. House of Representatives, which developed H.R. 6675, is not reflected in the language of the bill itself on matters related to participation of physicians. Examples are given below:

1. The committee report (p. 39, par. 3) states that "Your committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay." However, these words and phrases do not appear in the bill itself, and the matter is covered only by the requirements, which appear in both parts A and B, that payment is to be made only if a physician certifies to the medical necessity of the services furnished. The intent of the committee could be better implemented if the phrases in the first sentence of the report were included in the bill. It is suggested that the bill be amended to read, under section 1814(a) (p. 15, line 13), "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. The physician is to be the key figure in determining utilization of health services—and the physician is to be the one who decides upon admission to a hospital, orders tests, drugs and treatments, and determines the length of stay. For this reason, payment may be made only if * * *." The bill should be amended in the same way under section 1835(a) (p. 87, line 25).

2. The committee report (No. 213, p. 46, par. 1) states that "Your committee believes that benefits under the supplementary health insurance benefits program should be administered by the private sector. This form of admistration is particularly appropriate for the supplementary plan because of the benefits the plan would provide in the case of physicians' services. Private insurers, group health plans, and voluntary medical insurance plans have great experience in reimbursing physicians."

If the determination of what is a "reasonable charge" for physicians' services is to be made by a carrier organization, this should be done only by organizations nominated by the physicians themselves, as is provided for institutional nonphysician providers of service regarding hospital costs.

However, these phrases do not appear in the language of the bill itself. It is suggested that the bill be amended by inserting the opening sentence from the report into the bill and by adding a phrase to permit physicians to nominate the carrier organization to represent them such as is done (under pt. A, sec. 1816(a), p. 22, lines 9–12) for institutional, nonphysician providers of services. These additions would appear in section 1842(a) (p. 53, line 16); the opening lines of the section would then read as follows: "In order to provide for the administration of the benefits under this part, the Secretary shall to the maximum extent possible administer these benefits in the private sector of health insurance by entering into contracts with carriers. Such carriers may be nominated by any group or association of physicians, such as a county or State medical society, who wishes to have payments made under this part through a National, State, or other public or private agency or organization. These carriers will undertake * * *."

3. The committee report (H. Rept. 213, p. 38, par. 2) provides that "Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers would take action to assure that the charge on which the reimbursement is based is reasonable and 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, 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 intent of the committee, quoted above, that, "in determining reasonable charges" of physicians, "the carriers would consider the customary charges for

similar services generally made by the physician" and "the prevailing charges in the locality," does not appear anywhere in the bill itself. There should be full recognition of geographic variation as well as local custom and flexibility. It is suggested that the bill could be amended by adding the phrase from the report to section 1842(b)(3) (p. 55, line 24). This portion of the bill would then read as follows: "(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 in the full charge for the service; (reasonable charges will be determined on the basis of the customary charges for similar services generally made by the physician furnishing the covered services, and also the prevailing charges in the locality for similar services").

We urge that all inpatient hospital services under either of the proposed health insurance benefit programs of H.R. 6675 continue to exclude all physicians' services except those of an intern or resident-in-training under a teaching program. (sec. 1861(b)(3) and (4), (p. 64, lines 10, 11, 12, 15, 16, 17).)

If part 1 of H.R. 6675 should be adopted into law, it is suggested that, wherever possible, the administration of benefits for physicians' services make greater use of county and State medical associations (*a*) in review of claims, (*b*) in appraisal and control of quality, (*c*) in supervision and monitoring of utilization for both outpatient and inpatient care, (*d*) in mediation of misunderstandings and complaints, and (*e*) in establishing the level of "reasonable charges." A deep continuing liaison between the Department of Health, Education, and Welfare and professional medical associations can be very helpful in setting up departmental regulations.

The supplementary health insurance plan can have the effect of freezing and perpetuating at the present level of development for the American people, a system of medical care which is otherwise highly dynamic, rapidly evolving, and constantly improving. It can also freeze the financial underpinning by insurance which is now available for this evolving system of care. American systems of voluntary health insurance are very valuable and useful; they are also constantly changing and improving. The present stage of development in medical care and insurance is not final, finished, static, or permanently desirable. Each must remain flexible, adaptable, and responsive to local need, local customs, and local patterns and social change. This adaptability may be seriously impaired by the rigidity and inflexibility inherent in a single natonal system, tightly controlled by admnistrative regulations of one Federal agency, as proposed in these two programs.

The supplemental health benefits program, proposed for the first time this year, is not well understood by the public and is potentially destructive of existing patterns of medical care.

Section 1803 of the bill permits any individual to secure additional protection against the cost of any health service. Since the conditions of the two health benefits insurance programs for the aged create, in effect, an exclusive monopoly for this age group, no voluntary supplemental benefits can survive in the private sector and the permission becomes nearly meaningless for any individual.

The supplementary health insurance plan for the aged, as proposed in part 1 of H.R. 6675, is described as "voluntary." However, there is nothing "voluntary" about general taxation on U.S. citizens of all ages, which provides the matching $3 per month per aged person to be supplied by the Federal Government. Because of this subsidy, it is anticipated that from 80 to 95 percent of all U.S. residents age 65 or older will enroll. The effect, when coupled with the compulsory basic hospital insurance plan for all aged, is to eliminate any—and all—other types of health insurance for this age group. Any U.S. resident age 65 and older who wants heath insurance will have no available alternative to the Federal programs. The only option remaining is whether the individual enrolls in the Federal program or elects to have no health care insurance. Certain enrollment provisions further negate any "voluntary" aspect of the plan. (There are (*a*) the requirement that if an eligible person does not enroll within 3 years of the time he first becomes eligible, he is forever denied enrollment; (*b*) the requirement that an individual who drops his enrollment more than twice may never again enroll; and (*c*) the requirement that the premium paid by the enrollee be increased by 10 precent for each year he delays entering the plan.) The elimination of all voluntary alternatives makes the programs in fact—if not in name—a national compulsory system for the aged. It creates for all persons age 65 and older a completely nationalized health insurance system—which will quickly produce a completely nationalized medical care system.

Here is the kind of "combination in restraint of trade" which we profess to deplore in the private sector of our economy; a monolithic system, establishing a monopoly which defies any possibility of challenge or competition, and to which each individual age 65 and older must yield if he wants any health insurance at all.

It would be only natural that people under age 65 would come to feel that their tax payments, both of the special payroll tax for the basic hospital insurance plan and of the general tax for the subsidy to supplementary health insurance plan, create a vested interest for benefits which they would then like to receive at a younger age and at times of their own economic stress. The demands for extension of the program, both in scope and in application to younger age groups, may be expected to become almost irresistible in future years. The effect may quickly be a complete nationalized health care system for all ages in the United States. This implication underlies all consideration of these two proposed programs which masquerade under the honored name of "insurance."

We recognize, however, that other considerations may lead you, in your wisdom, to recommend the two medical care benefit proposals which are now included in part 1 of H.R. 6675.

If you should decide to recommend enactment of either or both of these programs, we have offered some constructive suggestions for changes which we believe might make these programs somewhat more acceptable and more effective.

The importance of maximum acceptability and effectiveness becomes clear with recognition that under any program, the responsibility remains with each individual American physician to decide, in each instance, whether conditions of the program will permit him to provide his highest quality of professional care to the patient.

After very careful and thoughtful study, the physicians of California believe that the national public interest will be best served if neither the basic hospital benefits program nor the supplemental health benefits program, as proposed for the aged by part 1 of H.R. 6675, is enacted.

For reasons already presented to you, we urge continuation of the present exception from self-employment coverage under the Social Security Act for services performed as a doctor of medicine (sec. 311(a)(1) (pp. 218 and 219, lines 1, 2, 3) of H.R. 6675 amends existing law by eliminating this sexception).

Thank you for your courtesy in permitting me to present these views for the California Medical Association.

REASONS WHY THE USE OF CARRIERS AS FULL INSURING UNDERWRITERS IS BETTER THAN THEIR USE AS LIMITED FISCAL AGENT ADMINISTRATORS

1. Premiums are not fixed and are subject to negotiations and adaptability to the local situation and individual need, which benefits the covered person and gives him the advantage of lower regional costs.
2. There is possible a better recognition of perfectly proper variation in costs and charges.
3. There is increased incentive, from competition between carriers, for economy and efficiency.
4. Scope of benefits can be adapted to the need of individuals and the local situation.
5. There is less extra noninsurance responsibility, such as overseeing utilization review and determination of "reasonable charges" and "reasonable costs," which are more properly the function of representative organizations of institutions or persons providing medical care.
6. There is greater opportunity for saving in premium cost made possible by favorable experience with individual groups on a geographic or other basis.
7. There can be greater responsiveness to changing conditions of medical practice, and to legitimate objectives and evolutions including voluntary evaluation and control of quality.
8. Individual patient's medical records are available only to the carriers and not subject to inspection by a large army of Federal agency people.
9. There is greater freedom of choice by the enrollee, among plans, on the basis of demonstrated quality and price difference.
10. There is greater freedom for the enrollee to judge scope and quality in the program and greater freedom for the carrier and the providers of service, including physicians.

11. There is less tendency for a rigidity of nationwide benefit scope to downgrade the entire spectrum of health care services by central control, to the level of the lowest common denominator through establishment of nationwide norms.
12. There is better balance between carrier and enrollee, or between carrier and Government, or between Government and hospital or physician, which, in normal insurance practice allows both sides to negotiate as equals. Under a Government plan with fiscal agents, the Government administrator has all the power and can dictate all decisions rather than participate in bilateral negotiations.
13. It permits the carriers to renegotiate with Government on the basis of experience—in the interest of the enrollee—the scope, cost, premiums, fees, and other features.
14. There is greater autonomy and self-determination which can permit the highest possible standards of care with the greatest professional freedom and responsiveness to the local point of view.
15. It supports—rather than destroys—for a large population segment which uses a substantial portion of the medical services of the Nation, existing voluntary prepayment and insurance systems.

Santa Barbara Plan Concept

1. Structure of the program

Origin

The program was promulgated on February 1, 1963, after 2 years of development and negotiation between the county medical society and county and State governments. It was conceived by the physicians of Santa Barbara County as an expression of their conviction that public supported medical care programs can operate best if they create conditions that make available to the welfare recipients the full medical resources at the disposal of the entire community; and if they vest the fullest measure of local control in those who ultimately provide the care. The program therefore has important new ingredients, which are philosophical as well as fiscal and operational: It is considered the first, though not necessarily the final, step toward a new concept which seeks to finance care of the highest quality under conditions which assure dignity to the patient, freedom of professional practice and participation in program design and control to those who serve the program—and to do so at the least cost to the taxpayer, be he at the Federal, State, or county level.

Benefit structure

The program parallels the benefit provisions of the public assistance medical care and medical assistance for the aged program, and covers under the prepaid plan the benefits which are provided by physicians. The other components of the programs, such as, for instance, dental services, drugs, hospital, and nursing home care, are administered by CPS under the conventional fiscal agency arrangement. By unifying the two arrangements; namely, prepayment and fiscal agency, under one administrative roof, it is possible to maintain fully coordinated administrative control over the utilization of the total program without costly and inefficient fragmentation.

Contractual relationship

The agreements were entered into between the county of Santa Barbara and California Physicians' Service with the concurrence of the State department of social welfare. In order to accommodate to the county's fiscal year, the first contract period covered February through June 1963, and subsequent contract periods cover the 12 months commencing July 1. The program is now in its third period. Almost 7,000 beneficiaries are presently covered.

The agreement for the prepaid plan provides for fixed rates per recipient per month for medical care, and separately for administrative expenses, broken down into the various categories of aid and MAA. It provides for review and renegotiation annually, but includes special provisions which automatically modify the agreement should the State plan change its benefit criteria or its professional fee structure. Thus, the prepaid program has a predictable medical and administrative dues structure, subject to renegotiation each year, while the fiscal program follows the conventional open ended arrangement, using the advance funding concept under which CPS is reimbursed for administration on a formula identical to that in other fiscal agency counties.

Fiscal provisions

The physicians of Santa Barbara County are in a sense "underwriting" the fiscal stability of this plan. They have undertaken the weighty commitment to a temporary fee reduction should the fiscal stability of their prepaid program make this necessary. On the other hand, a surplus, if it develops, is placed into a special program reserve which is earmarked exclusively for the benefit of the plan. CPS, as prepayment plan, provides its services on a no-profit-no-loss basis. The adequacy of rates, for medical care as well as for administrative expense, is reassessed annually.

Professional fees

Participating physicians are remunerated at the same level level as prevails elsewhere in the State under these programs. As described above, this level could be temporarily reduced until contract renegotiation in case of adverse financial experience.

Relationship to the county welfare department

Administration of the prepaid plan, as well as the fiscal agency portion, is closely coordinated with the local welfare department, and liaison with the medical consultant to the welfare department is in no way diminished by the prepaid concept. The consultant is a participant in the advisory and review activities of the medical society.

Advisory, review, and quality of medical care committees

Perhaps the outstanding feature of the Santa Barbara plan is the scope of its medical supervision. An advisory and review committee, made up of the leaders of the local medical society, extends its concern well beyond the activities normally carried on by local review committees. It adds to the traditional adjudication of problem cases and fee problems abroad, overall review of the program, its utilization, its trend and its future potential. It receives rather elaborate technical support from CPS, and works with a broad array of source materials in its continuous program evaluation. In addition, a separate committee was established for the review of the quality of care, which works in close collaboration with the CMA Bureau of Research and Planning.

Administrative mechanics

The prepaid plan seeks to incorporate as many features of a voluntary prepayment plan as possible under a publicly financed program. Beneficiaries receive identification cards similar to those of any other CPS member, and are therefore afforded the dignity of being unsegregated from the rest of the community seeking medical care. Physicians use the simple CPS billing form under the prepaid plan. Payments to physicians are made in conjunction with any other CPS payments in one simple, consolidated check.

Physician participation

Prior to promulgation of the plan, the county medical society contacted by mail each physician in the county with full particulars of the prepaid plan and of the commitment expected of each participating doctor. Each physician was individually given the right to indicate that he wished to abstain from participation. This resulted in an affirmative expression of opinion on the part of 97 percent of the doctor membership. Only one additional cancellation out of a membership of over 300 has since been recorded.

II. AN ASSESSMENT OF THE PROGRAM'S PERFORMANCE

To evaluate whether the plan has attained the objectives originally set for it, we must assess the quality and cost of care, the general satisfaction of the patient, the support of the plan by the great majority of physicians, the financial stability of the plan and its general acceptability to government. A number of research projects which will probe into these components in great depth are still under way. But a number of significant observations can already be made in a general assessment of this concept.

Physician acceptance

This is one of the important yardsticks of the program's performance, because the degree of the physicians' commitment is an essential prerequisite for a plan which seeks to demonstrate that a responsible profession, given freedom and the right administrative framework, can serve its community best. At the inception

of the plan 97 percent of the doctor community backed the program. The real test of support, however, must be found in the number of doctors actually treating beneficiaries of this plan. This was studied last year and it was found that about 90 percent of the privately practicing physicians had seen such patients. When it is borne in mind that the specialty of some physicians precludes their participation due to the program's benefit limitations, this is indeed an impressive figure. Formal withdrawal from the program has been confined to one or two physicians. These figures would indicate that we have in Santa Barbara County what might be termed "total" professional support.

Dispersal of patients

Another test of performance is seen in the utilization of the full spectrum of medical resources in the community through the eligible welfare recipients. Prior to promulgation of the prepaid plan, the great majority of welfare recipients was seen by a relatively few doctors. When a research team of the State department of social welfare first reviewed the prepaid plan, based on the initial few months' experience, it was found that this concentration had diminished, but that the majority were still seeking care through relatively few physicians. This was, of course, inevitable, inasmuch as the steady transition to more conventional patterns of care was just beginning at that time. Location of practice alone will continue to cause certain concentration, and certainly the Santa Barbara community is not entirely immune to factors which create similar conditions elsewhere. What is really significant is that there is afoot a continuing trend of patients previously concentrated among a few physicians to avail themselves of the total medical resources of the county.

Advisory and review activities

To the quality of care rendered, and to the best use of public funds which finance such care, this activity has been most significant. To begin with, the committee has to assess customary patterns of medical care such as they would apply to the community as a whole. Such norms, combined with a direct, personal acquaintance with the medical community, and with the peculiarities of practice on the part of individual physicians, gave the committee a yardstick whereby to evaluate the program in its entirety.

Particularly during the early meetings, the committee obtained from CPS a complete and detailed review of the utilization on the part of each physician. This represented the raw material which led into two main areas of committee investigation:

First, it made possible an assessment of the financial solvency of the program, the dispersal of the patients to the medical community, the apparent adequacy of care as compared to that which other segments of the community would be expected to receive, the use of consultants in treatment and the utilization of ancillary services. In other words, it allowed a continuous assessment of the basic criteria to which this plan was especially committed: Broad physician participation, ready availability of care, and quality at the lowest cost compatible with it. And it made possible corrective measures if they became necessary long before an insoluble crisis.

Secondly, this evaluation brought to light treatment patterns by individual physicians which warranted further investigation. This is a more customary committee activity, but here the activity is generated in two ways, through the committee's total program records and, as usual, through the administrator's claims department.

The high level of committee intervention has not been created by an unusual level of potential problem cases. They are here an expression of the complete meshing of the advisory function with the operations of the program, a composite of evaluation, guidance and self-discipline which is the cornerstone of the plan.

Patient satisfaction

The plan was to assure dignity, accessibility and quality of care. No poll has been taken of the patient's viewpoint, but we are told that the members are pleased, appreciate the absence of welfare identification, are not being embarrassed by unwarranted doctor demands for supplemental payments, and receive care readily and conveniently without discrimination.

Fiscal stability

At the end of the first contract period, it was possible to set aside a fairly substantial reserve, and it is expected that the second contract period which ended June 30, 1964, will again add to this reserve, which is fully vested in the program.

and is earmarked for its exclusive use. As the medical care rate structure, which has remained unchanged, was based originally on the experience of surrounding counties, the experience is indicative of prudent use through the local medical community. It also underscores in financial terms the basic merits of a prepaid plan under enlightened local medical guidance. In fact, it might warrant the conclusion that more adequate fees would be feasible without additional drain on public funds under this system. As to the cost of administration, CPS was able to pass on the economies feasible during the renewal year through a reduction of its administrative rates by about 27 percent as of July 1, 1964.

Research

An important ingredient of this program is to be joint research on the part of the State department of social welfare, the California Medical Association, and CPS into the validity of this concept. This activity is being pursued vigorously, and some very meaningful results may be seen before the end of the year. In the meantime, preliminary research rata are available and are the basis of this report. In addition, certain of the basic research activities are channeled into the advisory and review committee for their program assessment and utilization control.

Acceptability to government

It is essential that any publicly supported program must be acceptable to those in whom control of public funds is vested. At the county level it is our hope that the plan reduces involvement with a highly specialized activity to the barest minimum. At the State level (the source of about half the funds), we believe that quality and availability of care and predictable expenditures are important. And at the Federal level similar criteria appear important. All components of government are obviously interested in a structure which facilitates care undifferentiated because of financial circumstances, and which brings forth and cultivates the best that a responsible medical profession can offer to the community.

Average monthly medical care expenditure per recipient, April 1963 to March 1964—Public assistance medical care program

Category of aid	Santa Barbara County [1]	Area 1	State
Old-age survivors	$11.52	$13.72	$12.81
BL	11.02	13.96	13.30
Aid to totally disabled	15.04	21.42	19.96
Aid to families with dependent children	1.65	2.31	2.21
Average of the above principal programs	5.93	8.11	7.32

[1] Santa Barbara prepaid plan and fiscal plan.

Senator ANDERSON. Thank you, Doctor. I appreciate very much the fact that in your manuscript you indicated what you were going to read and speak about and what you were going to leave out, and without objection, the full text of the statement—as has already been done—the full text of the statement will appear in the record.

Doctor, how about the section where you list the reasons why the use of carriers as full insuring underwriters is better than their use as limited fiscal agent administrators; would you like that also?

Dr. TEALL. Yes, sir. The reason for that is covered in our supplemental statement, and that is the reason why we believe the Federal employees health benefits program which does use carriers as full-risk sharing underwriters rather than as fiscal administrators is a better approach. These were our study documents.

Senator ANDERSON. The Santa Barbara plan concept, I assume you wanted that too?

Dr. TEALL. Yes, sir. This has been introduced in our supplemental testimony. It has been a unique experience by direct carrier administration, and we believe it would be of some interest to you.

Senator ANDERSON. Without objection, they will all be included. Thank you very much.

Dr. TEALL. Thank you.

Senator SMATHERS. May I ask one question? In your last paragraph you say:

> We urge continuation of the present exception from self-employment coverage for services performed as a doctor of medicine.

Dr. TEALL. Yes, sir.

Senator SMATHERS. Do you, at the same time, recommend as a corollary recommendation an improvement of the law with respect to taking care of private pension programs?

Dr. TEALL. Yes, sir.

Senator SMATHERS. And retirement programs?

Dr. TEALL. Yes, sir. I would think this is a separate matter, and we certainly believe there should be more attention given, as you have already given, in your previous legislative record.

Senator ANDERSON. Thank you, Doctor.

Dr. TEALL. Thank you.

Senator ANDERSON. Senator Sparkman?

Senator SPARKMAN. Thank you, Mr. Chairman and gentlemen of the committee.

I simply wanted to introduce my friend here, Dr. John Chenault, who is the spokesman for the Alabama Medical Association. He is accompanied by Dr. Burlison and Dr. Donald. They, together with Dr. Chenault, constitute the committee representing the Alabama Medical Association.

Senator ANDERSON. Thank you, Senator Sparkman.

We will be very glad to hear from you, and if you will be seated with your associates there, you may present your statement.

STATEMENT OF DR. JOHN M. CHENAULT, MEDICAL ASSOCIATION OF THE STATE OF ALABAMA; ACCOMPANIED BY DR. PAUL BURLISON AND DR. JAMES DONALD

Dr. CHENAULT. Thank you, sir.

Mr. Chairman and members of the committee, I am Dr. John M. Chenault, a practicing physician from Decatur, Ala., a member of our State committee of public health, State board of medical examiners, and board of censors of the Medical Association of the State of Alabama. I am here representing that association, which is composed of some 2,200 physicians in Alabama. We are grateful for your invitation to appear before your committee, and for the opportunity to express our views and conclusions concerning this extremely important legislation, H.R. 6675.

In Alabama, we have a unique administrative situation. The Medical Association of the State of Alabama differs from all other State medical associations in that the entire physician membership is, by law, the State board of health and, as such, is charged with all matters pertaining to public health. Because of this responsibility, which we individually and collectively feel, we are greatly concerned in all matters of health legislation.

Senator ANDERSON. Do I understand that 2,200 members are on your State board of health?

Dr. CHENAULT. Yes, sir.

Senator SMATHERS. Briefly, how does it function, just through the officers?

Dr. CHENAULT. Through a committee that is elected from the voting body, the voting delegates.

The general provisions relating to the health insurance programs are, for the most part, unwieldly, and we believe unnecessary in our State. In Alabama, the State board of health has the responsibility for licensing and inspecting health care facilities, including hospitals and nursing homes. Our established procedure is efficient, adequate, and appropriate for our needs.

We oppose many of the provisions of this bill, especially part 1-A of title I—proposed new title XVIII—which provides financing of hospital care through social security. This legislation would centralize control over many aspects of the care of the sick. We feel strongly that there is a basic error in the concept of our Federal Government providing a service of this nature to the aged segment of the population.

It appears to us that, of necessity, the administration of the proposed program will result in control of both the vendor and the recipient of the services. We sincerely believe that such a step would be dangerous to the physical health of our people, not in the public interest, and an improper function of the Federal Government. The practice of medicine—art and science—is a highly individualized endeavor, fitting particular needs with best available remedies, and does not lend itself to rigid rules or regimentation.

The proposal is a radical departure from present procedure in that the Government undertakes the provision of services rather than funds for the needy.

As it is now written, H.R. 6675 excludes coverage of the services of pathologists, radiologists, physiatrists, and anesthesiologists as part of inpatient hospital services. We urge that this feature be retained as it now stands. The practice of pathology, radiology, anesthesiology, and physical medicine are branches of the practice of medicine just as are surgery, general practice, and internal medicine. The services of these physicians are not hospital services and do not belong in that

portion of the bill solely designed to offer hospital benefits. The approval of any amendment classifiying these four specialties as "hospital services" would force approximately 15 percent of this country's physicians to become salaried employees of hospitals rather than independent practitioners.

The use of a regressive tax to fund this proposal of health care, we feel is another basic error. While we make no claim as financial or fiscal experts, we understand some of the errors of a regressive tax. We consider it to be unjust to tax the working people of this country to provide health care for everyone 65 years of age, regardless of their financial need. It seems unrealistic to expect a young couple with children, and multiple costs-of-living payments, to be saddled with an additional tax for the care of all the elderly.

In Alabama, according to our latest available figures, 8 percent of the total population is 65 or over; 52 percent of our State's population is between the ages of 18 and 64; 50 percent of all the families in Alabama have an annual income under $4,000 and 71 percent have an annual income under $6,000. In Alabama, 50 percent of the nonwhite families have an income of less than $2,000 and the income of 80 percent of these families is under $4,000. A large percentage of this group are the so-called disadvantaged. The point is that the lower income families would pay a tax disproportionately high. We consider this to be unwise, unfair, and discriminatory against these very people whom we are all desperately trying to help, at both the State and Federal levels.

As to part B of title I, part 1—of part B of proposed new title XVIII—we favor provision of adequate health care for all the elderly. We support the concept of a voluntary insurance program but feel strongly that it should be administered by a State agency on the local level so that the peculiar needs of any area can be properly met.

Further we believe such a program should be limited to those in need. We feel that administration at the Federal level will inevitably result in inefficient operation of the program, and inadequate care for the aged's ills.

The physicians of Alabama respectfully remind you that we have always given freely of our time and talents for the needy. We desire and expect to continue to contribute our time and efforts, and we believe that we can best serve our patients without third-party interference.

The medical assistance program proposed in part 2, title I—new title XIX—greatly expands the Kerr-Mills Act. Our experience in Alabama with medical assistance to the aged under the Kerr-Mills law has been good. There has been a steady growth in utilization of this program. In 1962 there were 1,639 claims, for which hospitalization costs were $390,959; fees paid to physicians totaled $2,189. In 1964, 2,710 claims with hospitalization costs $836,864 and only $4,475

paid for physicians' services. During 1962, HOAP—hospitalization for old-age pensioners—hospitalization costs of 19,130 claims was $3,962,277 with $17,259 paid for physicians' services.

In 1964, $6,323,418 was paid for hospitalization for 26,369 claims. The total number of hospitalization claims for both plans in 1964 is 29,074, while 7,566 claims for physicians' services were filed. $7,160,283 were paid for hospital service, while $65,174 were paid for physicians' services.

This simply means that in many instances no claims were filed for the services of physicians.

We consider this to be further evidence that the Alabama physicians will cooperate in voluntarily furnishing health care services for the sick, the aged, and freely to the needy.

We favor this portion of H.R. 6675 since it appears to extend a program of medical care administered at State and local levels, a procedure which we have found to be workable.

The self-employed physicians in Alabama oppose their inclusion in the social security system. Historically, no group has been included under social security until its national organization has approved such inclusion, and in the case of self-employed physicians, this has not been done. Under the proposed combined social security and hospital benefits act, the self-employed individual would pay $355 on maximum annual earnings of $5,600 in 1966. This would gradually rise to $514.80 on annual earnings of $6,600 in 1987. Any self-employed person earning $6,600 annually would contribute $9,642.70 during the next 20 years of social security, and $5,148 for each succeeding 10-year period. This seems to be a poor investment, with no interest return. Physicians in Alabama rarely retire at any age, and almost never by age 65; thus they would not benefit from this program. Most physicians in Alabama, as elsewhere, already have private investment plans for retirement income. This additional tax may jeopardize many of these plans.

It is regrettable that the Members of the House of Representatives were denied the opportunity to debate the various features of H.R. 6675 before its passage. We urge the Senate to assert its independence and consider each proposal of H.R. 6675 separately, so that its good features may be adopted, and objectionable features rejected or amended.

Thank you for giving us this opportunity to help discharge our obligation to the people of Alabama in our effort to preserve for them the best possible health care plan. We hope that our opinions will be of some benefit to you in your deliberation. We would be pleased to attempt to answer any questions and to obtain additional information for you. We are submitting for the record charts and more details concerning MAA and HOAP utilization in Alabama.

Senator ANDERSON. Without objection those charts will be placed in the record.

(The documents referred to follow:)

Public assistance data

	Hospitalization for old-age pensioners		Medical assistance to the aged hospitalization		Physicians' services			
					HOAP		MAA	
	Claims	Amount	Claims	Amount	Claims	Amount	Claims	Amount
1961								
April	891	$52,260.80						
May	742	112 576.80						
June	846	122,634.27						
July	1,026	153 330.98						
August	952	143 241.57						
September	1,064	159,182.81						
October	1,197	201,674.28						
November	1,301	242,023.28						
December	1,204	230,235.62						
Total	8 923	1,417,169.41						
1962								
January	1,455	262,962.33						
February	1,506	276,654.87	17	$2,911.62	4	$40.00		
March	1,702	315,844.71	158	32,767.62	145	1,579.00	7	$81.00
April	1,384	250,739.29	131	27,614.85	148	1,666.00	13	134.00
May	1,530	276,931.68	137	27,463.97	257	1,628.00	20	235.00
June	1,590	299,956.06	146	29,476.93	149	1,678.00	26	315.00
July	1,766	331 085.76	161	36,249.17	164	1,828.00	18	215.00
August	1,604	375 235.19	184	42,696.28	140	1,665.00	22	246.00
September	1 651	372 499.96	160	39,706.18	169	2,066.00	25	296.00
October	1 635	370 357.39	167	40,688.40	138	1,640.00	19	209.00
November	1 343	314,775.45	145	42,168.57	107	1,290.00	7	100.00
December	1,964	465 235.12	233	69,214.21	181	2,179.00	31	352.00
Total	19 130	3,962,277.85	1,639	390,957.80	1,502	17,259.00	188	2 183.00
1963								
January	2,052	481,281.46	181	57,260.71	189	2,214.00	15	176.00
February	1,757	413,810.05	194	58,702.62	221	2,114.00	22	281.00
March	2,737	625,583.76	292	90,084.67	366	2,952.00	26	299.00
April	1,416	326,433.45	193	60,156.17	395	3,352.50	21	257.00
May	2,449	578,647.38	291	82,842.45	574	5,525.50	52	651.50
June	1,770	416,407.37	232	64,074.86	521	4,091.25	33	408.50
July	2,007	451,092.51	203	60,379.58	487	4,001.50	23	288.00
August	1,862	429,910.57	206	59,522.53	390	3,530.00	33	367.00
September	1,963	448,858.81	169	49,536.40	401	3,489.50	25	290.00
October	1,967	434,493.29	236	66,888.40	533	4,125.00	27	311.00
November	1,973	483,659.53	129	35,971.40	283	2,217.00	17	225.00
December	1,575	389,484.72	108	64,358.91	386	3,163.00	10	116.00
Total	23,528	5,479,452.88	2,534	749,778.70	4,751	40,835.25	304	3,670.00
1964								
January	2,570	630,991.54	262	89,347.77	857	6,428.00	50	652.00
February	2,260	547,795.45	232	69,532.36	469	4,464.50	25	277.50
March	2,398	570,265.11	259	79,787.11	707	6,092.50	33	320.00
April	2,266	537,219.15	236	71,732.67	655	5,534.50	29	413.00
May	2,206	522,408.88	236	69,022.85	548	3,368.50	28	301.00
June	2,010	471,708.67	218	39,281.41	600	4,883.00	23	295.00
July	2,166	489,923.83	237	72,475.29	676	5,433.00	21	233.00
August	2,029	464,114.16	219	55,818.02	580	4,935.50	51	686.00
September	2,195	507,284.99	195	63,866.69	550	4,274.15	23	285.50
October	2,295	563,615.96	232	74,455.38	718	6,208.50	26	284.00
November	2,041	518,254.40	203	71,281.51	388	3,455.50	25	291.00
December	1,939	499,836.78	181	60,263.10	458	3,571.50	21	237.00
Total	26,369	6,323,418.92	2,710	836,864.16	7,206	60,649.15	360	4,476.00
1965								
January	2,587	665,152.64	250	76,068.79	765	6,087.50	27	325.00
February	2,150	529,780.60	223	70,486.49	389	3,092.50	25	317.00
March	2,696	680,491.16	253	84,922.57	554	4,642.50	22	276.00

Senator ANDERSON. I am not going to spend any time in trying to argue, but you say that the self-employed physicians in Alabama oppose their inclusion in the social security system. Historically, you say, no group has been included in social security until its national organization has approved such inclusion.

You may be right, but my impression was the dentists were put in, and the American Dental Society did not approve.

Dr. CHENAULT. I think the American Dental Society did approve.

Senator ANDERSON. Did they approve?

Dr. CHENAULT. It was my understanding that they did approve it.

Senator ANDERSON. Will someone here give us expert testimony on that case?

Mr. JAMES W. FORISTEL. I am James Foristel. I understand they did disapprove twice, and finally approved, at least on an elective basis, and were taken in in 1956.

Senator ANDERSON. I am not sure. I thought they disapproved all the way through, and finally approved the action at a later time.

Mr. FORISTEL. The same story for the lawyers.

Senator ANDERSON. Good. I am glad to have an expert witness to give us the information.

Any questions?

Senator SMATHERS. No questions.

Senator ANDERSON. Thank you very much for coming here.

Dr. Flannery.

STATEMENT OF DR. WILBUR E. FLANNERY, PAST PRESIDENT, PENNSYLVANIA MEDICAL SOCIETY

Dr. FLANNERY. Mr. Chairman and Senator Smathers, I am Wilbur E. Flannery, a practicing physician in Newcastle, Pa. I am here as the immediate past president of the Pennsylvania Medical Society which consists of some 12,000 members, and having the present duty to express to your our opinions with reference to the legislation before you.

We have a six-page statement which, of course you have the long statement in your hands, and our oral presentation will be briefer.

We would like to request, if it is possible, to put in the record the statement that was made before the House Committee on Ways and Means November 20, 1963, in connection with H.R. 3920 of the 88th Congress, if this can be made a part of the record, or available to Senators to look at. We believe it makes some points of interest with reference to our opinions about the legislation.

Senator ANDERSON. Without objection that will be done at the end of your statement today.

(The document referred to will be found at the conclusion of the statement of Dr. Flannery, p. 672.)

Dr. FLANNERY. Thank you.

There are aspects of H.R. 6675 which we favor, such as that portion which would increase the cash benefits to social security recipients and the concept of voluntary participation in medical insurance subsidized by general fund revenues. Our position on the measure as a whole, however, must be one of opposition. This is why:

1. Those who are able to pay for their health and medical care should pay for it, regardless of age. To give financial support to those who do not need it is—

Economically unsound: It would waste Government aid on those who do not need it instead of focusing it on those whose limited income calls for help. We in Pennsylvania have proof that the aged who need help can be given adequate help.

Philosophically unwise: To encourage dependence upon Government aid rather than instilling a spirit of personal responsibility intensifies rather than solves the problem. "Give a hungry man a fish and you have fed him for a day; teach him how to fish and you have fed him for a lifetime."

Pennsylvania has proof that an adequate program for providing the aged with help in meeting the cost of hospitalization and nursing home care can be built on the need for such care. Our medical assistance for the aged program is helping about one-fourth of all age 65 and over hospitalized patients, without a deductible feature and for longer periods of illness than would the hospital benefits portion of H.R. 6675.

2. Financing should come from a tax imposed in proportion to the taxpayer's ability to pay.

Additional taxes on those who can afford them the least would create a problem for the lower wage earner that would be greater than the problem the legislation proposes to solve. We are concerned with the economic difficulties that such regressive taxes are certain to cause. We are concerned with the stifling change in mental attitudes that result from greater and greater payroll taxes on those in our lower wage brackets.

3. The departure from cash benefits to service benefits removes from the recipient the freedom to purchase that which most adequately meets his individual needs.

In the departure from cash benefits to service benefits, there is no provision for higher hospital costs which have been increasing at a 7-percent annual rate for some years. Thus, the Department of Health, Education, and Welfare will have to purchase those services at "market prices" or, it must control the vendors.

There is widespread misunderstanding among persons of all ages as to what services H.R. 6675 would provide. Should the bill pass in its present form, the disillusioned age 65 and over recipients who expect considerably more benefits than the bill provides would exert massive pressures for expansion of the benefits, pressures that could not be resisted.

The service proposals make a further departure in that they are not even subject to the same earned-income limitations as are the cash benefits.

4. The administration of medical matters should rest in the hands of those with the highest medical training and should take place at the lowest practical governmental level.

Administration at the lowest level is the most economical administration.

The Pennsylvania Department of Public Welfare administers our medical assistance for the aged program and does it well, but welfare departments in general certainly are not as well qualified as are health departments to administer health services. There are numerous references in H.R. 6675 to the establishment of advisory and regulatory bodies and of authority, without guarantees that there would be adequate representations of medical doctors, and without specifying that medical decisions would be made by persons medically trained.

5. The public should be spared the lower quality of medical care resulting from over and/or poor utilization of health care facilities and of the services of the members of the health care team.

Physicians control to some degree the utilization of certain health care facilities, but such control is limited by human pressures to which there is a practical limit. The increased demands on facilities that the passage of H.R. 6675 would bring would result in deterioration of the hospitalization and medical care provided to the entire public.

6. The direct or indirect fixing of prices, for whatever the purpose, stifles incentive, halts and reverses progress, and hurts those whom it would profess to help.

In various parts of H.R. 6675 there is the establishment of control or the ultimate authority to control. These are detailed in the American Medical Association's statement and we will not repeat them.

Under our current system, every physician in private practice and every hospital certainly is in competition with every other accessible physician and hospital. Ignore, if you choose, the dedication that the vast majority of physicians bring to their calling, but the competition that exists under free, non-State medicine dare not be discarded by anyone who shares our goal of providing the highest possible quality of medical care.

Those physicians who have chosen specialties of anesthesiology, pathology, radiology, and physiatry should not be set apart from the other practitioners of medicine.

These services should not be under the hospital benefits portion of H.R. 6675. The practice of those four medical specialties differs in no way from the practice of other medical specialties. Among the many expressions of opposition to any such inclusion was one in a letter to us from the president of the Pennsylvania Society of Anesthesiologists.

He said in part:

> * * * the most recent surveys have indicated that on a countrywide basis, more than 85 percent of all practicing anesthesiologists practice on a strict fee-for-service basis. They render their own statements to patients for whom they administer a service and are paid directly by the patient. The hospital does not enter into such relationships any more than it does in the relationship between a surgeon and a patient * * *.

Hospitals do not provide the highest medical skills and arts; the physicians do, and may they continue to do so if the high quality of medical care in this Nation is to continue to advance.

We do not feel the hospital benefits portion of the bill should be expanded. We are suggesting that the hospital benefits portion is the wrong way to solve any existing problem. It does not differentiate between the needy aged and the affluent aged in the degree of help it provides.

We believe the direction of H.R. 6675 would be impossible to reverse when it proves to be unsatisfactory, and expansion to a complete system of Government medical care would be inevitable.

Benefits should be provided in proportion to need and taxes should be collected in proportion to ability to pay.

It is our earnest hope that this committee will propose an alternative that will not unnecessarily burden the lower wage earners and will not place or drive the profession represented by the Pennsylvania Medical Society into any further degree of State-controlled medi-

cine—reduced quality medicine. One such alternative with proven workability exists in Pennsylvania.

We offer every resource at our command to assist in arriving at such a national alternative. And with our offer to help in any way consistent with our convictions, I extend on behalf of my 12,000 fellow physician members our thank you to the members of this committee for this opportunity to present our views.

(The prepared statements of Dr. Flannery follow:)

STATEMENT OF THE PENNSYLVANIA MEDICAL SOCIETY ON H.R. 6675, SOCIAL SECURITY AMENDMENTS OF 1965

Mr. Chairman and members of the committee, I am Wilbur E. Flannery, a medical doctor specializing in internal medicine, and I am appearing here today as immediate past president and spokesman of the Pennsylvania Medical Society. We are opposed to certain provisions of H.R. 6675 because as physicians and citizens we believe the measure would lower the quality of medical care and that it is economically unsound and philosophically unwise.

Our opposition to certain basic points of H.R. 6675 was detailed in our statement presented in opposition to identical points that occurred in H.R. 3920 of the 88th Congress, a statement presented on November 20, 1963, to the Committee on Ways and Means of the U.S. House of Representatives. We request that we be allowed to submit that statement as part of the record of this hearing because it has a direct bearing on H.R. 6675, describes and identifies our medical society, and describes a Pennsylvania program which is helping without embarrassment those aged who need help in meeting their hospitalization costs.

There are aspects of H.R. 6675 which we favor, such as that portion which would increase the cash benefits to social security recipients and the concept of voluntary participation in medical insurance subsidized by general fund revenues. Our position on the measure as a whole, however, must be one of opposition. We tell why in six points:

1. Those who are able to pay for their health and medical care should pay for it, regardless of age.
2. Financing should come from a tax imposed in proportion to the taxpayer's ability to pay.
3. The departure from cash benefits to service benefits removes from the recipient the freedom to purchase that which best meets needs.
4. The administration of medical matters should rest in the hands of those with high medical training and should take place at the lowest practical governmental level.
5. The public should be spared the lower quality of medical care resulting from over and poor utilization of health care facilities and of the services of members of the health care team.
6. The direct or indirect fixing of prices, for whatever the purpose, stifles incentive, halts and reverses progress, and hurts those whom it would profess to help.

In addition, we have this opinion concerning efforts to bring about an amendment to broaden coverage to additional physicians' services:

Those physicians who have chosen to practice the specialities of anesthesiology, pathology, radiology, and physiatry should not be set apart from the other practitioners of medicine.

An official body of the Pennsylvania Medical Society reviewed an advance copy of today's statement of the American Medical Association and is in agreement with essential points made in it. To avoid repeating that statement, we limit our presentation to the six mentioned points with which we in Pennsylvania have had additional experience and have made additional observations. In respect to these points:

1. Those who are able to pay for their health and medical care should pay for it, regardless of age.

To give financial support to those who do not need it is—

(*a*) Economically unsound: It would waste Government aid on those who do not need it instead of focusing it on those whose limited income calls for help. We in Pennsylvania have proved that the needy aged, indeed, the younger too, can be given adequate help and that need and eligibility for that help can be predetermined.

(b) Philosophically unwise: To encourage dependence upon Government aid rather than instilling a spirit of personal responsibility intensifies rather than solves the problems. "Give a hungry man a fish and you have fed him for a day; teach him how to fish and you have fed him for a lifetime."

We in Pennsylvania have proof that an adequate program of providing the aged with help in meeting the cost of hospitalization and nursing home care can be built on the need for such care. In Pennsylvania, age 65 and over citizens can determine their eligibility for such care in advance and thus can arrange their finances to meet their individual situations. Our program of medical assistance for the aged is helping about one-fourth of all age 65 and over hospitalized patients without a deductible feature and for longer periods of illness than would the hospital benefits portion of H.R. 6675. Fewer than one out of 200 such patients do not pay or do not have their hospital bills paid. This is a record unequaled by any other age group. This program has no deductable feature because when a program is based on need, tax dollars are more wisely used and thus can provide more help for those who need help.

We hope that constructive legislation will result so that the aged who need help will receive it in a more economical, more inclusive, more practical way than is proposed in H.R. 6675. The details of Pennsylvania's working program are given in the November 20, 1963, statement of the Pennsylvania Medical Society which we have asked be made a part of the record of this hearing. Since the time that statement was submitted, the number of age 65 and over persons in Pennsylvania being helped has been increased through the elimination of any relatives' responsibility and through a vast educational program carried out by the Pennsylvania Medical Society and the Department of Public Welfare.

2. Financing should come from a tax imposed in proportion to the taxpayer's ability to pay.

Surely additional taxes should not be imposed on those who can afford them the least. They would create a problem for the lower wage earner that would be greater than the problem the legislation proposes to solve. Additional taxes on our lowest wage earners without regard to their ability to pay reduces their already minimal living standard and reduces their incentive to work and to attempt to provide for themselves and their families. It further reduces the flowering of those human qualities which have been responsible for our Nation's progress.

Why impose the most regressive of taxes? Should not they be imposed in proportion to ability to pay? Physicians also are citizens, and as citizens we are concerned with the economic difficulties that such regressive taxes are certain to cause. We are citizens and also physicians and as physicians we are concerned with the stifling change in mental attitudes that result from greater and greater payroll taxes on those in our lower wage brackets. Such attitudes can mean the difference between incentive and resignation.

3. The departure from cash benefits to service benefits removes from the recipient the freedom to purchase that which most adequately meets his individual needs.

We commend the drafters of the measure for that portion which would increase cash benefits for social security recipients. Are our aged, to a greater degree than younger persons, unable to use a dollar wisely? Is it proposed that eventually their groceries be purchased for them, rather than to give them the dollars to purchase food which is to their individual tastes?

In the departure from cash benefits to hospitalization service benefits, there is no provision for the inflation of hospital costs which have been increasing at a 7-percent annual rate for some years. There is every reason to believe that hospital costs will continue to increase and the Department of Health, Education, and Welfare will have to purchase those services at market prices or, it must control the vendors of these services.

There is widespread misunderstanding among persons of all ages as to what services H.R. 6675 would provide. The most common misunderstanding is that it will take care of all hospitalization and medical bills for all persons age 65 and over. Should the bill pass in its present form, the disillusioned age 65 and over recipients who expect considerably more benefits than the bill provides would be certain to start massive pressures for expansion of the benefits, pressures that could not be resisted. Expand the benefits, and the costs increase. Increase the costs, and there would have to be a further regressive tax increase. Increase the taxes and many who can afford it the least are hurt the most.

The service proposal makes a further departure from a fundamental concept of the social security program. The services in the hospital benefits portion of H.R. 6675 are not even subject to the same earned income limitations as are the cash benefits. It fails to include in the service benefits the safety factor which has operated so successfully in the cash benefits portion. We favor the raising of the earned income limitations embodied in this bill and it would seem to be a simple matter to have proposed, at the very least, that the service benefits be subject to the same earned income limitations as are the cash benefits. The bill proposes that the earned income limitations be raised so that $1 of cash benefits be deducted for every $2 of earned income up to $2,400 annually, and that $1 of cash benefits be deducted for every $1 of annual income above $2,400. Then, in the hospital service benefits portion it does not propose that $1 of covered hospitalization benefits be removed from coverage for every $2 of earned income up to $2,400 annually, nor that $1 of covered benefits be removed from coverage for every $1 of annual income above $2,400. It is inconsistent. The greater outlay as a result of this inconsistency could be used to better advantage in providing greater help to those who have the greatest need for help.

Cash, not services, means that the physician would be working directly for the patient rather than for a governmental program.

4. The administration of medical matters should rest in the hands of those with the highest medical training and should take place at the lowest practical governmental level.

Administration at the lowest practical governmental level is the most economical administration.

In Pennsylvania, we are proud of our current department of public welfare administration of our medical assistance for the aged program, but welfare departments in general certainly are not as well qualified as health departments to administer health matters. The fractionalization of the administration of health care is costly and detrimental to the quality of care provided to recipients.

There are numerous references in H.R. 6675 to the establishment of advisory and regulatory bodies and authority without guarantees that such advisory bodies would have adequate representations of medical doctors and without specifying that authority for medical decisions would rest in the hands of persons medically trained. Further clarification of these points is given in the statement of the American Medical Association.

5. The public should be spared the lower quality of medical care resulting from over and poor utilization of health care facilities and of the services of members of the health care team.

You may say the physician controls the degree of utilization of certain health care facilities and that is partially true. From a practical standpoint, the degree of such control is considerably less than some would believe. Physicians are subject to human pressures and there is a practical limit to such resistance. Physicians, especially in Pennsylvania, have been at work for years to correct any over and poor utilization of facilities so that hospitalization costs can be kept as low as possible, but there is ample evidence that where there is a "free" service, there is increased utilization. In most instances, increased utilization is over and/or poor utilization.

Various hospital planning groups have been estimating that the passage of H.R. 6675 would bring almost immediately a need for a 25-percent increase in facilities and services of members of the health care team. This would result in deterioration of the hospitalization and medical care provided to the entire public. Under our present system, we are not experiencing the British difficulty of having to undergo a waiting period of 6 to 24 months for elective surgery.

Under our present system, we have an almost unlimited number of specialists able to purvey the best type of medical service in virtually every crossroads hospital.

6. The direct or indirect fixing of prices, for whatever the purpose, stifles incentive, halts and reverses progress, and hurts those whom it would profess to help.

We mentioned the danger inherent in the provision of services because the Government must purchase services at market prices or, it must control the vendors of the services. In various parts of H.R. 6675 there is the establishment of control or the ultimate authority to control. These are detailed in the American Medical Association's statement and we will not repeat them here.

Under our current system, every hospital certainly is in competition with every other hospital accessible to the patient. Every physician in private practice is literally in competition with every other accessible physician. Ignore, if you

choose, the dedication that the vast majority of physicians bring to their calling, but the competition that exists under free, non-State medicine dare not be discarded, dare not be glossed over by anyone who shares our goal of providing the highest possible quality of medical care. Fixed payments never can provide the impetus toward perfection inherent in competitive fees-for-services, be those fixed payments set by the hospital, the Government, or any other group.

Those physicians who have chosen specialties of anesthesiology, pathology, radiology, and physiatry should not be set apart from the other practitioners of medicine.

Those who would sweep under hospital and governmental control the professional medical services of the above four named specialties would make an arbitrary decision. The services are not now covered under the hospital benefits portion of H.R. 6675 and should not be, for the practice of those four medical specialties differs in no way from the practice of other medical specialties.

Louis Goodman, M.D., president of the Pennsylvania Association of Clinical Pathologists, in an April 27, 1965, letter to the Pennsylvania Medical Society asked for our support in attempts to prevent any inclusion of the above medical specialty services in the bill.

Seymour Schotz, M.D., president of the Pennsylvania Society of Anesthesiologists, Inc., in a letter dated April 30, 1965, wrote us in part:

"It is commonly stated that the services of anesthesiologists are a part of a hospital service. The most recent surveys have indicated that on a countrywide basis, more than 85 percent of all practicing anesthesiologists practice on a strict fee-for-service basis. They render their own statements to patients for whom they administer a service and are paid directly by the patient. The hospital does not enter into such relationships any more than it does in the relationship between a surgeon and a patient. Therefore any attempt to alter this relationship would work a serious inequity against the practicing anesthesiologist. All organizations of anesthesiology are unanimous in their opposition to any inclusion of anesthesiologists' services in hospital services."

Similar expressions have been made by officials of the other two mentioned medical specialties.

It may be that the American Hospital Association has seized upon this bill as a vehicle for its members to gain a wider degree of control over the provision of hospital and medical care and we submit that hospitals are not and should not be the practitioners of the art and science of medicine. Hospitals exist so that physicians better can provide their services to their patients. The hospitals do not provide these highest medical skills and arts; the physicians do, and may they continue to do so if the high quality of medical care in this Nation is to continue to advance.

Before concluding, we point out that we do not feel the hospital benefits portion of the bill should be expanded to cover certain services that are not now covered in the bill. We are suggesting that the hospital benefits portion is the wrong way to solve any existing problem the aged have in meeting their hospitalization care costs.

H.R. 6675 would place a burden on those aged who need the most help because it does not differentiate between the needy aged and the affluent aged in the degree of help it provides. We believe the direction of H.R. 6675 would be impossible to reverse when it proves to be unsatisfactory, and expansion to a complete system of Government medical care would be inevitable.

Benefits should be provided in proportion to need and taxes should be collected in proportion to ability to pay.

There are many alternatives to H.R. 6675 and to the financing method it would employ for the hospital benefits portion. It is our earnest hope that this committee will propose that the Congress of the United States accept as an alternative one that will not unnecessarily burden the lower wage earners and will not place or drive the profession represented by the Pennsylvania Medical Society into any further degree of State-controlled medical care. One such alternative, an alternative with proven workability, exists in Pennsylvania's program of providing hospitalization for those who need help.

We offer every resource at our command to assist in arriving at such an alternative.

And with our offer to help in any way consistent with our convictions, I extend on behalf of my 12,000 fellow physician-members our thanks to you the members of this committee for this opportunity to present our views.

STATEMENT ON H.R. 3920, PRESENTED TO THE COMMITTEE ON WAYS AND MEANS, NOVEMBER 20, 1963

(By W. Benson Harer, M.D., immediate past president, Pennsylvania Medical Society)

The Pennsylvania Medical Society, representing 12,000-member medical doctors in the State, has long advocated and supported such legislation as will accrue to the health and well-being of the public. Specifically, our society was one of the first to study and act on medical care for the aged. In 1959, it started a program for improved medical service and is attempting to expand that program throughout the State. The program establishes a system of evaluation and review procedures to provide control against misuse of health care facilities.

H.R. 3920 is not needed in Pennsylvania. There is no medical care for the aged problem in Pennsylvania requiring any type of additional Federal legislation. As evidence, our society surveyed 10 representative general hospitals in the State. It reviewed a total of 132,807 hospital admissions between January 1, 1962, and July 1, 1963. Of these admissions, 10,096 or 15.1 percent, were persons age 65 or older. Of this older group, 47.6 percent paid their hospital bills with Blue Cross plan insurance; 29.3 percent with commercial insurance or cash; 20.5 percent had their hospital bills paid under the Kerr-Mills law; only 2.6 percent had not paid their hospital bills at the time of the survey. Hospitals, then, received payment for 97.4 percent of all patients age 65 or older. And since the time of the survey, Kerr-Mills implementation has been expanded and further payments have reduced the nonpayers to less than 1 percent.

The cost of providing medical assistance for the aged and old age assistance coverage in Pennsylvania averaged $23.5 million annually and under the improved provisions, is expected to cost $26.5 million a year. Under H.R. 3920, Pennsylvania taxpayers would be forced to pay $152 million more taxes the first year alone, based on the administration's own questionably low estimates. In other words, Pennsylvania residents would be trading a working program costing $26.5 million annually for an inadequate, compulsory program costing a minimum of six times as much. And under H.R. 3920 the cost would be borne by many least able to bear it.

With the Federal Government returning general tax dollars to the States through the Kerr-Mills law, the aged in need will continue to have adequate medical care at the lowest possible cost and without further endangering the freedom of our citizens.

We urge the abandonment of H.R. 3920 as not only undesirable legislation, but an unneeded legislation.

(Testimony follows:)

I am W. Benson Harer, a medical doctor, now in my 40th year of practice in Upper Darby, Pa., where I specialize in obstetrics and gynecology. I am appearing here today as immediate past president and the spokesman of the Pennsylvania Medical Society, a nonprofit organization of 12,000 physicians. It is a constituent of the American Medical Association and has 60 component county medical societies in 63 of Pennsylvania's 67 counties.

The organization that I represent is 115 years old and is actively engaged in extending medical knowledge, advancing medical science, elevating and maintaining medical education, upholding the ethics and dignity of the medical profession, and in health education of the public.

In fact, it is considered a leader in enlightening and directing public opinion concerning health and hygiene because it has not shirked the responsibilities that are the lot of a leader.

As a specific example, the Pennsylvania Medical Society has been extremely active in carrying out its responsibility in connection with advocating and supporting legislation that will improve the health and general well-being of the public that the society serves.

The society wishes to present evidence to you here today to show that the legislation you are considering simply is not needed in Pennsylvania. This may sound surprising to some of you. It is nontheless true. What has been done in Pennsylvania can be done in other States.

MEDICAL SERVICE IMPROVED

Medical care for all ages always has been the society's concern. Of special concern has been the care of older persons. Our society was one of the first to recognize the position into which older persons were being relegated. It studied

the situation, disseminated information on the proper care of the elderly to our members and to the public, and advocated and supported specific legislation and other measures to meet their needs. In other words, our society not only recognized the existence of the social changes affecting the aging, it acted to combat undesirable results.

One of our society actions that aided in reaching a solution was the establishment of a program for improved medical service. The program was started in western Pennsylvania about 7 years ago and is spreading throughout the Commonwealth. The program, simply explained, seeks to insure the maximum amount of the highest quality health care for the public at the most reasonable cost. Physicians, acting through their medical society and cooperating with health care partners such as hospitals, voluntary prepayment agencies, and commercial health insurance carriers, have been able to serve health care consumers more efficiently. The program establishes a system of evaluation and review procedures which are guided by established standards for the quality, cost, and utilization of health care facilities so as to provide controls against misuse and provide a stimulus for continual improvement in performance. The program is working and is working well and it benefits the general public as well as the over-65 segment of the State's population. Just last month, our house of delegates voted to work to extend this program throughout the State.

GOOD LEGISLATION SUPPORTED

This activity of the medical profession has been praised by many persons and organizations. As an example, the Hon. Francis R. Smith, former insurance commissioner of Pennsylvania, last year said in a speech in New York City:

"I directed the Blue Cross to take specific actions to minimize any overutilization that might exist. I asked for the cooperation of medical societies, doctors, hospitals, and the public. * * * I am pleased with the cooperative response of interested persons and organizations * * *."

The Pennsylvania Medical Society always has supported suitable welfare legislation that has had either a direct or indirect effect on the aged indigent, such as the public assistance law. Through the years, we have supported amendments to give public assistance recipients as much additional coverage as the State could afford. In 1959, we supported in our general assembly passage of a bill which provided that aged indigent persons may be cared for in foster homes at State expense. In 1958, the State Department of Public Welfare began to pay for needed nursing home care of the indigent.

We have been in the forefront in insisting that nursing homes achieve maximum efficiency. We have encouraged the enactment of appropriate practical nursing licensure laws to assure that nursing care is provided by competent individuals for all of our citizens, especially those over 65.

This year, our society saw the passage of a series of bills it has long advocated and fought for—bills that provide a broader, more adequate implementation of the Kerr-Mills law in Pennsylvania.

HOSPITAL SURVEY CONDUCTED

We point to this broader implementation as an example for other States and as part of the evidence for the statement I made earlier—that there no longer is a medical care for the aged problem in Pennsylvania requiring any type of additional Federal legislation.

We will now support that statement.

In discussing the following points, it would be helpful to know the extent of the Kerr-Mills implementation that existed in Pennsylvania from January 1962, to September 1963. It is outlined for your information in appendix A to this testimony.

Those members of this committee previously acquainted with the Kerr-Mills implementation as it existed in Pennsylvania prior to September of this year and those who have read appendix A to this testimony can see the administrative problems that were created by the methods of eligibility determination. One could reach the conclusion that such methods of determination would guarantee the program's eventual failure.

Now, let us see if this program was a "failure."

To find out, the Pennsylvania Medical Society in July of this year completed a survey of 10 general hospitals in Pennsylvania. The hospitals were selected as representative of those serving all of the varied areas of the Commonwealth,

with different industries, differences in economic well-being, different geographical areas, and with different ratios of age-65-and-over residents to the general population.

Seven of the hospitals surveyed serve highly industrialized, moderate-to-low income areas where the unemployment in July 1963, ranged between 12 and 13 percent. All except one of the hospitals serve areas where the ratio of residents age 65 and over is somewhat above the national average. The one exception serves an area where the ratio is almost the same as the national average.

The eighth hospital serves an area with both industrial and rural residents with moderate to low incomes and with an employment rate of 8.6 percent. The ninth also is an industrial-rural area with an unemployment rate of 6.1 percent. The tenth hospital is in a large metropolitan, highly industrialized area with an unemployment rate of 7 percent and with residents with moderate incomes. It is a teaching hospital and handles more clinic (free) cases than the average.

EXCELLENT PAYMENT RECORD

The survey figures were obtained from the hospitals themselves in August of 1963. We will present the figures as compiled in August although a check made just a few days ago reveals that with the passage of time, the already small number of nonpaying patients is reduced drastically. That reduction will be explained after we present the August survey figures.

A total of 132,807 hospital admissions since January 1, 1962, were reviewed. Of this total number of admissions, 19,996, or 15.1 percent, were persons 65 years old or older.

Of the 19,996 persons 65 or older admitted to the hospitals:

9,528, or 47.6 percent, paid the hospital bill with Blue Cross plan insurance.

5,866, or 29.3 percent, paid the hospital bill with commercial insurance, or cash.

4,097, or 20.5 percent, had their hospital bills paid under the Kerr-Mills law.

504, or 2.6 percent, had not paid their hospital bills at the time this survey was taken.

These hospitals, at the time of the survey, had received payment for 97.4 percent of all persons age 65 or over.

It is enlightening, to say the least, to note that 76.9 percent of these 19,996 patients paid their hospital bills either by private voluntary insurance or cash.

Thus, even under the limited Kerr-Mills implementation that then existed in Pennsylvania, it paid the hospital bills for 20.5 percent of the over-65 patients admitted to these hospitals. There is every reason to believe that the experience of these 10 hospitals does not differ in any way from that of other hospitals across the State. Studies made in other hospitals bear this out. A breakdown of the information gathered in this survey is provided in appendix B to this testimony.

RESULTS OF A RECHECK

In 1962 the Congress of the United States, in considering an added program of financing medical care for the aged through an increased social security tax, would, therefore, have been considering a program which would have taxed every working Pennsylvanian to meet a need that existed with less than 2.6 percent of those persons over age 65 who were admitted to a hospital. In fact, this figure probably will be reduced to less than 1 percent by the passage of time.

We say less than 1 percent because of what we found in a recheck made a few days ago. We selected for rechecking hospital H, as listed in appendix B, because its percentage of nonpaying patients age 65 and over was closest to the survey average of 2.6 percent. This is what we found:

In the 3 months since hospital H was first surveyed, the percentage of nonpaying patients age 65 and over dropped from 2.5 percent to 0.4 percent. This was accompanied, naturally, by a 2.1-percent increase in the number of over-65 patients who paid their hospital bills with private insurance or cash.

Hospitals tell us that this change is a natural one—that included in the original group of nonpayers are such patients as accident victims whose temporary nonpayment occurs because of litigation; persons who need a few weeks to withdraw money from a time savings account; some persons, who, although eligible for Kerr-Mills assistance, refuse it because they prefer to meet their own obligations; and, a few real hardship cases generally reflected in the less than 1 percent of nonpayers that ultimately result.

The experience of hospital H is not unique. We had time to check with 2 other hospitals in the original 10 and found that their percentage of nonpaying patients age 65 and over also has been greatly reduced since August. The final payment picture cannot be obtained for at least a year after the patient's release from the hospital, it was pointed out. The hospital officials also tell us that nonpaying hospital patients of all ages average out to about 5 percent. Thus, the loss to hospitals from age-65-and-over patients is less than one-fifth of the loss incurred from all patients.

Now, let me tell you how this small need has been further diminished.

The 1963 session of our general assembly passed, with the full support of the Pennsylvania Medical Society, measures which will increase the scope of our Kerr-Mills program and should, with earnest and sincere administrative effort, make it one of the finest programs in the United States. Our new Governor has insisted that our Kerr-Mills program be one of the best. The Kerr-Mills law in Pennsylvania, beginning September 1 of this year, is far better than its predecessor.

KERR-MILLS IMPLEMENTATION BROADENED

Beginning September 1, the following gratifying modifications were added to our law:

The asset and income limits for those applying for medical assistance to the aged were increased from $1,500 to $2,400 in the case of single persons, and for married couples from $2,400 to $3,840, because the overwhelming number of those applying for medical assistance who were ineligible were found to be so by reason of asset and income limitations. The estimated additional cost in State funds for those added benefits will be approximately $975,000 a year.

The placing of liens on estates of recipients has been eliminated. The recovery provision has been unpopular and in some instances may have caused persons to refrain from seeking to establish medical assistance eligibility. The estimated annual cost of this provision is $720,000 in State money.

Under another new and very important provision, the State will determine annual eligibility whether the persons are sick or well. Such eligibility may be established in advance of need. After eligibility once has been established, the renewal process will be a simple one. This will eliminate the need for sick persons to discuss their financial position at a time when they are undergoing physical pain and hardship.

Another provision will give the State department of public welfare the authority, with the approval of the secretary of the budget, for adjusting the responsibility of relatives downward or possibly eliminating it. There has been $1 million in State funds budgeted for this provision.

Finally, a provision for public nursing home care has been extended to include posthospital care in non-tax-supported nursing homes, not in excess of 60 days during any 12-month period; if prescribed by a licensed physician; and if initiated within 5 days following inpatient hospital care. This provision is expected to cost about $250,000 in State funds.

It is estimated that an additional 7,000 persons in Pennsylvania over the age of 65 will benefit from these new provisions at an additional estimated cost in State funds of $2,945,000.

DOES NOT CORRECT CAUSE

When one considers the data presented by the survey of 10 hospitals and considers the increase in the scope of the Kerr-Mills program effective September 1, it causes us in Pennsylvania to wonder why the Federal administration and some segments of the Congress feel that additional Federal legislation is required. What Pennsylvania has done with the Kerr-Mills law can be done by other States.

Adequate Kerr-Mills law implementation, then, meets the need. We are aware that it does not solve the cause of that need and as good physicians we cannot treat symptoms without seeking to eliminate causes.

It is the Pennsylvania Medical Society's long-range goal to reduce the need for Kerr-Mills funds and to reduce the need for any government-operated plan—or scheme.

How? By seeking to establish eventually an actuarially sound system of prepayment insurance so that workers can make systematic payments into a fund to be used for their own medical care—not for someone else's medical care.

The cost to the State of providing medical care coverage under the medical assistance for the aged and the old-age-assistance programs in Pennsylvania for

the first 17 months of the MAA implementation averages out to $1,959,823 a month or $23,517,876 for a year of operation. The new MAA provisions effective September 1, 1963, are estimated to bring the annual cost to $26,462,873.

With the added scope of the program cleared during the new State administration, the future in Pennsylvania should prove conclusively that local and State governments can meet problems and administer programs without additional Federal intervention and control.

COST OF H.R. 3920

Remember that estimated figure of $26.5 million, given for the cost of providing medical care for the aged needy in Pennsylvania for a year? If H.R. 3920 should be cleared by this committee and passed by the Congress, Pennsylvania taxpayers would be forced to pay $152 million more in taxes the first year alone. And this estimate is based on the administration's own figures, despite the fact insurance actuaries believe the proposal will cost at least twice the administration's estimate. The bill which you are considering would trade a medical care for the aged program that works and will cost $26.5 million a year in Pennsylvania for an inadequate compulsory program that would cost the State's residents a minimum of six times that amount.

To provide some added statistical information, there are approximately 1,120,000 Pennsylvanians over the age of 65. About 40,000 of these older residents of the State are old-age-assistance recipients under the Federal-State public assistance program which has been in operation in Pennsylvania for more than 25 years. Subtracting 40,000 old-age-assistance recipients from the total number of Pennsylvanians over the age of 65 leaves 1,080,000. Certainly, some of these 1,080,000 aged persons experience hardship in meeting the expenses of their medical care to the same degree that they experience hardship in meeting any of their other living costs. What our hospital survey would indicate, however, is that the portion of the aged who require hospital care has more means available for meeting the cost of that care than does any other segment in Pennsylvania. What's more, 85 percent of all persons 65 or older are in good health.

The Pennsylvania Medical Society almost hesitates to mention the above facts. It almost fears that the figures will provide certain segments of government with ammunition for demanding a program of medical care for those under 65, financed with an added social security tax. Those persons who are unable to meet living expenses certainly require help, whether those expenses are for food, for shelter, for clothing, for transportation, or for medical care. The Pennsylvania Medical Society will always be in the forefront of those who help that segment of our population which needs help. It would seem, from the survey and rechecks conducted in our State that fewer than 1 out of every 100 persons over the age of 65 who are hospitalized does not pay his or her hospital bill or have it paid under the Kerr-Mills law. I'm sure that most nonpaying persons have just reasons for nonpayment, but do the members of this committee feel that in order to pay part of the hospital bill of that 1 person out of 100 in Pennsylvania, there should be established a massive taxation and administrative paycheck-eating monster to pay for some of the hospital costs of all 100 persons?

INSURANCE PROGRAMS GROWING

The Pennsylvania Medical Society wholeheartedly believes that the members of this committee cannot objectively weigh the facts that we have presented and arrive at a conclusion other than the obvious one—that the legislation you are considering simply is not needed, that legislation already enacted into law provides an adequate, fair vehicle for meeting the medical care costs of the overwhelming majority of those over 65 who need help.

What we have presented so far only scratches te surface of the evidence that shows the concern and activities of our society in the areas of medical care for the aged.

The Pennsylvania Medical Society has provided the stimulus for a Blue Shield senior citizens insurance program. It's being offered on a voluntary basis to Pennsylvanians 65 years of age and older and, like previously existing Blue Shield programs, permits persons to secure voluntary, prepaid medical care insurance regardless of age or condition of health.

Under the new senior citizens insurance program, an individual with an income of less than $1,500 or a person with dependents having an income of under $2,400 will receive covered services without additional charges from the 15,000

Pennsylvania physicians who have adjusted their fees to participate. Subscription rates for this plan are $1.83 a month for a single person, and $3.66 for a subscriber with one or more dependents. These low rates are possible because the physicians have voluntarily lowered their fees. At the present time, over 4 million Pennsylvanians have Blue Shield coverage and can continue this coverage past the age of 65. Blue Shield presently covers a grand total of 371,482 persons over the age of 65 in Pennsylvania. In addition, many other persons have other forms of health insurance. Pennsylvania's Blue Cross plans offer over 65 coverage to individuals and to groups, and feature extended protection, including nursing home care in addition to hospital care and visiting nurse care.

SOCIETY WORKS WITH AGED

The Pennsylvania Medical Society has been supporting a move in Pennsylvania to make it legal for insurance carriers to band together to provide a nonprofit program similar to the "65 plans" in several other States. Such statewide underwriting pools are gaining favor across the United States and our society hopes that they will continue to grow where needed. It will support legislation to enable the creation of such an underwriting pool in Pennsylvania.

To touch on some of our society's other activities in connection with the aging, the Pennsylvania Medical Society was instrumental in organizing the Pennsylvania Council on Health Care of the Aging. The council is composed of representatives of hospitals, nursing homes, dental, pharmaceutical, nursing, and medical organizations. This council has been supporting conferences on health care of the aging throughout the State. Our society's commission on geriatrics, established in 1952, has been assisting the development of appropriate courses in medical schools which will acquaint medical students with the problems they will be facing in the care of older citizens. This same commission has been instrumental in developing programs for the X-ray screening of older persons and has cooperated with various departments of State government in advising them of the necessary requirements for nursing homes. Our society has been stimulating the development of home care services which are of principal interest to the aged. Nutritional manuals have been distributed by our society to help physicians and others provide proper diets.

What have the individual Pennsylvania physicians been doing? They have a long and commendable history of supplying eight different types of medical facilities for the aged and needy. Traditionally, physicians working in all of the facilities and as individuals and private practitioners of medicine have offered freely and generously their services in furnishing medical care to the aged in Pennsylvania.

Our hospitals are partially reimbursed by the State for the care that is rendered to needy patients, but I would like to point out that the physicians working in these hospitals caring for these patients have never received any reimbursement. These doctors provide medical care needed by indigent patients and prefer not to have more of their time, after caring for every such patient, devoted to filling out involved government forms.

Are the free services a physician provides impossible to describe in dollars? No, according to the publication New Medical Materia which took a random sampling across the United States in 1960 and came up with this report:

That Pennsylvania physicians provided $41,960,000 worth of free care during 1960. This free care was apportioned on the following basis: 28.4 percent resulted from treating private patients without charge; 37.3 percent resulted from hospital ward service; 24.3 percent was provided in outpatient clinic service; 10 percent resulted from free care to all other persons, including physicians' relatives, students, campers, amateur athletes, clergymen, emergency cases, and charity cases.

Many of us, after discussions with our patients, are of the opinion that the majority of the citizens of Pennsylvania prefer to provide for their own health care upon retirement, on a voluntary basis. It is our considered opinion that the aged in Pennsylvania who need assistance for their medical care, do receive it through the aid that is already available from Federal, State, and local governments, and with the continued cooperation of those who provide health care.

To summarize this area, the physicians in cooperation with the health insurance plans have made available voluntary insurance that will protect those aged whose life savings would be endangered in the event of a prolonged illness. That such voluntary insurance is meeting the need is evident in the results of the hospital survey that we have presented to you here today.

"PROBLEM" IS DIMINISHING

Our survey showed that more than three out of every four persons 65 or older admitted to hospitals took care of their hospital obligations with Blue Cross, other types of health insurance, and with cash. With this must be considered the fact that health insurance plans are still growing and that with their current noncancelable features, the number of insured is certain to increase in the years ahead. In other words, the legislation you are considering is aimed at a "problem" that is diminishing every year and will continue to grow less and less. Kerr-Mills can and is meeting the "grey area" between indigency where old-age assistance meets the problem and ability to budget for health insurance.

It all leads us to the conclusion that there is no need to force each and every working person to submit to an added tax under social security to provide a program of Government-directed payments for a portion of the medical care expenses of all persons over the age of 65. The proposal being considered by this committee today would give aid to anyone over the age of 65 whether aid is needed or not. It is a proven fact that many of our social security recipients have adequate funds to buy the luxuries of life as well as to provide for their own medical care. In fact, 200,000 older Americans had incomes of $20,000 or more in 1962. To tax a less fortunate individual to provide a fund for payment for the more fortunate is so far from the principles of democracy that it causes us to shudder. We have found that Pennsylvanians over the age of 65 believe in the principles of democracy and wish to be free and independent and have bought private insurance for their own protection. These individuals can choose their own hospital, can select their own doctor, and are not being subsidized by a younger and frequently less fortunate generation.

For anyone or any group to insist on the passage of legislation to provide aid for an area where the need is not clear causes one to question the motives behind such urgings. Previous proponents of legislation much like H.R. 3920 publicly admitted that their proposals were aimed at providing a foot in the door so that the step could be followed with the full-scale adoption of socialized medicine with its heavy tax burden and its Government control of the hospitals and the medical profession.

NOT AN INSURANCE PROGRAM

The proposed law will provide care in only those hospitals which have made agreements with the Federal Government. It further provides for the payment of funds to hospitals for care rendered by pathologists, radiologists, anesthesiologists, and physiatrists. These people are all doctors of medicine, practicing in a specialized field of medicine. How soon will you be asked to include the surgeon, the internist, or the general practitioner? How soon will you be asked to provide complete hospitalization and medical care for every man, woman, and child in the United States once our aged, regardless of need, have become direct wards of the Federal Government?

H.R. 3920 is designed as a foot in the door. With its social security financing mechanism, it taxes many who can afford it the least to pay for the current medical costs of many who do not need and do not want the help. It is not an insurance program. It would use current income to pay for current costs which would mean that as the percentage of our over-65 population increases and as the cost of hospitalization rises, the tax rate would have to be increased again and again. H.R. 3920 is a monster that would eat away chunks of the incomes of those in the lower income brackets.

With the evidence that we have presented, with the Federal Government returning tax dollars to the individual States through the Kerr-Mills law, the aged in need will continue to have adequate medical care at the lowest possible cost and without further endangering the freedom of you, me, or our children. The legislation that you are considering here today is a threat to our cherished freedom and democracy and we urge you to abandon it as not only undesirable legislation, but as unneeded legislation.

On behalf of the Pennsylvania Medical Society, I wish to thank the members of this committee for this opportunity to present our views. You have been kind. I hope you feel that we have been convincing.

(Appendices A and B follow:)

[Appendix A]

KERR-MILLS PROGRAM IN PENNSYLVANIA JANUARY 1962 TO SEPTEMBER 1963

The medical-assistance-for-the-aged program in the Commonwealth of Pennsylvania specified the particular elements of medical care within the scope

of the provisions as follows: (1) Inpatient hospitalization; (2) posthospitalization home care when provided by a hospital; (3) nursing care in the home; and (4) nursing home care in county institutions. The law did not authorize medical-assistance-for-the-aged payments for any other elements of medical care.

The amount of the assistance to be provided to eligible beneficiaries also was specified in our public assistance law. The beneficiaries of our State medical-assistance-for-the-aged program were defined in the public assistance and support law as follows:

(A) Over-65 residents of the State who did not have a spouse or dependent child living with them were entitled to medical care within the scope of the program when that medical care costs more than the sum of these four amounts: (1) The amount by which the clear market value of real and personal property exceeded $1,500, excluding his home, household furnishings, car, and life insurance with cash surrender value not exceeding $500; (2) the amount legally responsible relatives (spouse and children) were financially able to pay toward the cost of the medical care as determined by the State department of public welfare; (3) six times the difference between the aged person's average monthly gross income and $125; and (4) the amount of any health insurance or other benefit available to meet the cost of the medical care.

(B) Residents who had a spouse living with them were entitled to specified medical care when the cost of that medical care exceeded the sum of these four amounts: (1) The amount by which the clear market value of the real and personal property belonging to the person or spouse exceeded $2,400, excluding their home, household furnishings, car, and the spouse and aged person's life insurance with cash surrender value not exceeding $500; (2) the amount legally responsible relatives (children) could pay as determined by the State department of public welfare; (3) six times the difference between the average monthly combined gross income of the person and spouse and $200; and (4) the amount of any health insurance or other benefits available to meet the cost of medical care.

Aged residents of the State who had dependent children living with them were eligible for specific care when the cost of that care was more than the sum of the four amounts given in paragraph (B) above, except that the income figure in item (3) was increased by $41.66 for each dependent child.

The Pennsylvania support law stipulated in general terms how the amount required of legally responsible relatives was to be determined. The same law also made the medical-assistance-for-the-aged recipient's home and other property available after death for repayment of the amount granted. Although it prohibited the placing of any lien against the recipient's property during his lifetime, except when that payment was improperly obtained, the law makes an individual's property liable for medical-assistance-for-the-aged repayment or, for that matter, any other type of public assistance granted to or in behalf of the individual's spouse.

[Appendix B]

Survey of 10 general hospitals in Pennsylvania conducted in August 1963, of 65-and-over admissions

Hospital	Total admissions	Admissions over age 65	Number paid by Blue Cross	Cash, private insurance	Paid by Kerr-Mills	Not paying by any means
A	11,832	2,291	1,314	679	278	20
B	5,699	588	203	284	97	4
C	19,671	2,588	1,463	677	386	62
D	11,706	1,830	1,026	630	159	15
E	18,495	2,844	1,548	768	444	84
F	18,043	2,440	1,074	559	732	75
G	18,193	3,265	1,068	844	1,240	113
H	11,020	1,422	727	418	242	35
I	10,930	1,955	758	844	290	62
J	7,218	773	347	163	229	34
Totals	132,807	19,996	9,523	5,866	4,097	504
Percent	100	15.1	47.6	[1] 29.3	20.5	[2] 2.6

[1] Time INCREASES this percentage.
[2] Time DECREASES this percentage.

Survey of hospitals A through H covers 1962 calendar year, survey of hospital I covers 1962-63 fiscal year; survey of hospital J covers January 1 to June 30, 1963.

(Explanation follows:)

Survey data.—The hospitals checked in the survey cover a broad range of geographical and economic areas in Pennsylvania. They range from hospitals in the largest cities to community hospitals serving rural areas. All except J serve areas where the number of residents age 65 and older is somewhat above the national average. Hospitals A through G serve highly industrialized, moderate to low-income areas which as of July 1963, were averaging between 12 and 15 percent unemployment. Hospital H also serves an industrialized area, but the unemployment rate is 8.6 percent and it is in a moderate- to low-income section. Hospital I serves an industrial-rural area, the unemployment rate is 6.1 percent and it is in a moderate- to low-income section. Hospital J serves a large metropolitan highly industrialized area with an unemployment rate of 7 percent. It is in a moderate-income area, but as a teaching hospital, handles more clinic (free) cases than the average.

Time changes statistics.—Earlier this month, we rechecked several of the hospitals involved in the survey to determine how time changes the survey results. Hospital H, for instance, with percentages in all categories close to the total survey averages, was rechecked. This is what we found:

In 3 months, the percentage of nonpaying patients age 65 and over dropped from 2.5 to 0.4 percent.

There was a resulting increase of 2.1 percent in the number of patients paying with private insurance or cash—from 29.4 to 31.5 percent.

Hospital officials tell us that this change is a natural one—that included in the original group of nonpayers are such patients as accident victims whose temporary nonpayment occurs because of pending litigation; persons who need a few weeks to withdraw money from a time savings account; some persons, who, although eligible for Kerr-Mills assistance, refuse it because they prefer to meet their own obligations; and, a few real hardship cases generally reflected in the less than 1 percent of nonpayers that ultimately result. The experience of hospital H is not unique. In spot checking other hospitals in the original 10, we found their percentage of nonpaying patients age 65 and over also has been reduced since August. These hospital officials tell us that the final payment picture cannot be obtained for at least a year after the patient's release from the hospital.

Senator ANDERSON. Any questions?

Senator SMATHERS. I have no questions. Thank you, Doctor.

Senator ANDERSON. Thank you.

I stated, Doctor, that we got very little testimony on what the doctors thought about the correctness of the $72 payment that is going to be made per year for these extra services. If you have any doubts as to the financial solvency of the program we would like to have them raised. We would be glad to have that comment. I know you feel eldercare is a good way of taking care of it. That income is a proper way to evaluate these things.

I was supplied a memorandum a while back that in 1961 there were 17 Americans with incomes of more than $1 million a year, who paid no taxes of any kind. That is true because of the oil depletion allowance, capital gains, trust arrangements, and so forth, and they would be eligible under eldercare because they have no income, taxable income. The had a $1 million income. So you do have problems in these fields, and I just hope you would bear in mind that we have problems, too, as we start to deal with it in the Finance Committee.

Senator DOUGLAS. I ask consent that there be printed as a part of today's hearings the statement of Dr. A. A. Adams, president-elect of the American Chiropractic Association.

(The statement referred to follows:)

STATEMENT BY DR. A. A. ADAMS, PRESIDENT-ELECT OF THE AMERICAN CHIROPRACTIC ASSOCIATION

Mr. Chairman and members of the committee, the American Chiropractic Association is fully in accord with the objectives of Federal legislation to provide

needed health services to our older citizens. In a letter to President Johnson on January 8 of this year, this organization endorsed the President's position and supported the passage of the medicare bill. Our endorsement was offered because the need for adequate health protection for millions of our Nation's older citizens has been so long unfulfilled.

We believe that those older citizens who are to benefit by this bill should have the American right of free choice to select the method of health care which they deem best. This choice does not appear to be granted to them in the legislation this committee is now considering.

It appears to us that the provisions of the legislation are, in some areas, so restrictive of chiropractic services as to deny recipients the helpful and beneficial care of doctors of chiropractic. This is particularly true of the voluntary extended care portion of the bill. Therein we note that chiropractic health care is available provided the doctor of chiropractic is a member of the staff of a "home health agency" and that his services be classified "medically necessary."

The fact that "home health agencies" are either wholly or to a great extent under the exclusive control of the medical profession tends to exclude doctors of chiropractic from membership and/or participation in the services performed by these agencies. We further understand that chiropractic care, if it is to be rendered at all by these agencies, must be specified by a doctor of medicine. The history of this type of arrangement has demonstrated it to be tantamount to an exclusion of chiropractic services.

We respectfully submit that the voluntary feature of the bill should include chiropractic health service as a matter of the patient's choice. If there be a stipulation in this instance, it should be that the practitioner has been properly examined and duly licensed in that State in which he practices. Please bear in mind that in this section the patient pays part of the cost from his own funds.

Under title XVIII, which expands those services now provided by existing Kerr-Mills statutes, we understand chiropractic health services are provided as an option to be accepted or rejected by a given State. Here we submit this option tends to diminish the value of the license issued for the practice of chiropractic in the various States. This optional inclusion relegates chiropractic to a secondary level of care. It is our contention that those fields of health care which are properly examined and duly licensed by the various States should participate under this section equally under the law.

Rather than to limit inclusion of these legally recognized and licensed professions, their helpful ministrations should be permitted and encouraged.

This legislation far surpasses any like social legislation in the history of our Nation. The benefits of this needed legislation have been withheld from the people in part through the efforts of the American Medical Association, its affiliated subdivisions, and agencies under its partial or direct control. Now, ironically, it seems that the opponent of the legislation has been given control of its administration.

We most emphatically declare that this legislation must be evaluated in terms of the restrictions we have called to your attention. It is the aged population of our Nation for which this legisltaion is being considered * * * not any segment of the health professions. If this legislation does not more adequately include services of other than medical doctors, their organizations, enterprises, and subsidiaries, it will fall short of the noble purposes for which it was conceived.

The American Chiropractic Association and its thousands of members wish to devote such valuable talents as this profession possesses toward the betterment of the health and pleasures of our aged citizens. Our profession can accomplish these purposes only with proper recognition and fair participation assured under law.

We are about to enter a phase of legislation which will possibly endure for the rest of our existence as a nation. This is the time and the place to make those changes which assure the right of citizens to express their free choice in the selection of their personal health care. There is no greater individual choice than that by which life itself is either bettered or maintained.

Thank you.

Senator ANDERSON. Thank you very much. We thank all the witnesses, and we are very sorry we had to run late. We will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 12:30 p.m. the committee recessed, to reconvene at 10 a.m., Wednesday, May 12, 1965.)

SOCIAL SECURITY

WEDNESDAY, MAY 12, 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, Long, Talmadge, McCarthy, Williams, Carlson, and Curtis.

Also present: Senator Cooper of Kentucky; Elizabeth B. Springer, chief clerk.

Senator ANDERSON. The committee will be in order.

It is my very great pleasure this morning to welcome my colleague, Senator Javits to testify. I have publicly and privately expressed my appreciation to Senator Javits for the fine study which he and his group made on the whole health care question and I personally welcome you.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. Thank you, Mr. Chairman.

May I express my thanks to the committe and to its principal administrative aid, Elizabeth Springer, to its chairman, Senator Byrd and the present occupant of the chair, Senator Anderson, and his colleagues for giving me this opportunity to testify. I know the tremendous time limitations, and so without further ado I would like to proceed.

I am especially happy that the chairman today is my long-time colleague in arms in this struggle, and it is a historic moment, Mr. Chairman, because I am confident that we shall have a medical care for the aging bill in this session of the Congress. I know of no one who has a right to be more gratified than the present occupant of the chair. It really will be the crown of a great senatorial career. I sincerely hope that the bill will bear his name, as King-Anderson has for so very long. It certainly is well deserved.

For my own part, my credentials are that I have been very active in this field since 1949 when the first bill was introduced in the House, in which I joined with a number of colleagues who since became very famous in my party, like former Vice President Nixon, Christian Herter, former Secretary of State, Thruston Morton, who is now in the Senate, and others. In 1960, together with other members of the Republican Party, I sponsored the bill for medical care for the aging based on general-revenue financing, which was the main alternative to

the bill President Kennedy and the present occupant of the chair advocated in the Senate. Neither got anywhere until 1964 when, teaming up with the present occupant of the chair, and Senator Gore, the Senate did pass a bill, having very much the basic principles of the bill which is before us. Mr. Chairman, I support, in essence, the bill which is before us, and my testimony this morning is designed to offer certain constructive suggestions for amendment which I think could make the bill even more useful.

The basic lines of principle upon which it is constructed are a social-security-financed hospitalization plan, plus a complementary opportunity for insurance for full medical coverage. This was also the basic principle of the so-called Anderson-Gore-Javits bill. It is the basic principle developed by the National Committee on Health Care of the Aged, a very distinguished committee which reported in 1963, and which I had the honor of organizing. I ask unanimous consent to include the names of the members of that committee in the record and pertinent excerpts from their report.

Senator ANDERSON. Without objection that will be done.

May I stop you there for just a moment, Senator Javits?

When the American Medical Association testified yesterday a statement was made. [Reads:]

> To this day eldercare remains the only proposal before Congress for providing health care for the aged that was drawn up in consultation with the medical profession.

I want to ask the distinguished Senator from New York if his group had the benefit of any consultation with the medical profession.

Senator JAVITS. The answer is distinctly "Yes," Mr. Chairman. I would like, as long as the Chair will allow me—I am so concerned about intruding on time—to read into the record now the names of the members of the committee which unanimously reported in favor of a bill along the lines of the bill that passed the Senate in 1964 and this bill.

Senator ANDERSON. Did you not have a former Nobel Prize winner?

Senator JAVITS. Exactly right. May I just read the names, Mr. Chairman?

Senator ANDERSON. Yes.

Senator JAVITS. Arthur Flemming, who was the chairman, is the president of the University of Oregon and former Secretary of Health, Education, and Welfare. The others were Russell Nelson, president of the Johns Hopkins Hospital, an M.D. Dr. James Dixon, also an M.D., president of Antioch College. Dr. Vernon W. Lippard, dean of the Yale Medical School; Dr. Dickinson W. Richards, Lambert professor of medicine emeritus, of Columbia College of Physicians and Surgeons; and Dr. Russell Lee, founder of the Palo Alto Clinic.

Now, in addition to these very distinguished doctors other members of the committee were Winslow Carlton, the chairman of Group Health Insurance; Marion Folsom, former Secretary of Health, Education, and Welfare, now treasurer of Eastman Kodak; Aurthr Larson, director of the Law Center at Duke University; John C. Leslie, a leading businessman and high official of Pan American Airways. His presence on the committee was as chairman of the Committee of the Community Services Society of New York; Thomas M. Tierney, a director of the Colorado Hospital Service, that is equivalent to Blue

Cross and Blue Shield; Herbert Yount, who was former executive vice president of Liberty Mutual Insurance; and the study director was Dr. Howard Bost of the University of Kentucky.

It was, as is evident from the distinguished membership, a very composite panel and had very distinguished medical advice.

Senator ANDERSON. I thank the Senator for that statement, because a member of my staff is in constant touch with his work. We had a chance at firsthand to appraise the efforts that the Senator from New York and his panel made. It was a distinguished panel and I thought it was fine, the studies made by that panel. I knew they consulted the medical profession and had full regard for the medical profession and I objected to the statement of the AMA.

It was not true that the AMA's plan was the only program with medical attention and I thank the Senator from New York.

Senator JAVITS. May I have unanimous consent to include the excerpts from the report as part of my testimony?

Senator ANDERSON. Without objection that will be done.

Thank you.

Senator JAVITS. Mr. Chairman, proceeding further, may I say that it took this committee a year to turn out its report but it was financed from private sources.

(The excerpts and list referred to follow:)

PROPOSED SOLUTION: A DUAL PUBLIC-PRIVATE HEALTH INSURANCE PROGRAM

The central purpose of an American solution to the problem of financing the health care of present and future generations of the aged must be to encourage and protect the independence and dignity of the individual. In its basic approach to this problem, our Nation must aim at preventing dependency as a concomitant of the deterioration of health in the declining years of life.

This requires a shift in public policy from placing major reliance upon charity and welfare assistance measures to placing emphasis upon the development within the Nation of health insurance for the aged. Public assistance programs present the prospect of great increases in requirements for public funds without accomplishing the objective of preserving the independence of elderly people or of reducing the economic hazard of illness as a threat to their independence. By their nature, such programs, including the Kerr-Mills program, deal with dependency after it occurs; health insurance, by reducing the cost which must be met at the time of illness to a level that is manageable, can prevent dependency and encourage self-reliance.

Clearly, the solution required in America today and for the future lies in actions which will achieve the health insurance coverage called for by the risk of illness in old age.

To accomplish the necessary development of health insurance for the aged, the committee proposes a dual public-private program, consisting of separate and distinct plans in the respective sectors of the economy. These plans are equally essential and should be complementary. Together they should provide balanced and effective basic protection covering roughly two-thirds of the aggregate health care costs incurred by the aged, leaving the remaining costs to be met by the individual on an out-of-pocket basis or through supplementary private insurance.

The public plan, in the committee's view, should utilize the principle of contributory social insurance to cover all persons 65 years of age and over, with payments collected during the working years of all employed and self-employed persons. The most appropriate area of protection to be provided by the public plan is institutional care, which is the most frequent cause of financial shock loss to the aged. The extent of this protection under the proposed plan would represent approximately one-third of the aggregate health care costs of the aged.

Another third of these costs, the Committee believes, should be the subject of special private insurance covering the largest noninstitutional costs that occur

most frequently among the aged. Special efforts are called for in order to bring the cost of such basic, complementary private coverage within reach of most of the aged, to whom the most economical and efficient forms of insurance are not ordinarily available. The Committee sees a need for congressional action to permit insurance organizations to join together in concerted efforts to provide low-cost protection on a mass-enrollment basis.

These components of the proposed dual program for the aged are both mutually reinforcing and mutually dependent. The Committee urges that one aspect not be considered out of the context of the other; rather, they should be considered together. To this end, the Committee recommends the establishment of a National Council on Health Care of the Aged, which would keep both the public and private components of the program under continuing review.

Under the proposed program, the health services that are to be financed will be obtained and rendered within the American system of medical care, the same system which serves the general population of the Nation. The financing of health care costs by the program will be supportive of the patient-physician relationship requisite for good medical care. The program will strengthen the economic base supporting the operation and improvement of the health care establishment throughout the Nation, helping to stimulate expansion of needed health care resources to serve all groups.

To provide guidelines for developing health insurance for the aged under broad national policy, the Committee has formulated a number of principles. These are set forth below and are discussed in the sections of the report which follow. We believe that through combined public and private action embodying these principles, a solution to the problem of financing the health care of the aged will be attainable in a way that is compatible with, and in fact will strengthen and reinforce American traditions and values.

GUIDING PRINCIPLES FOR PUBLIC INSURANCE

(1) A long-range public plan should be established, based on the principle of contributory insurance and calling for all employed and self-employed persons to participate during their working years, so that upon reaching age 65 all will have the protection provided under the plan without further payment.

(2) The long-range public plan should be self-financed by a separately designated payroll tax, collected as a part of the social security tax and equally shared by employees and their employers (or paid by the self-employed), with the benefit level under the plan tied to the proceeds from this source. Contributions should be placed in a special trust fund committed to provide stipulated benefits after age 65 to those under the plan.

(3) The extent of health insurance protection provided by the public plan should be designed to offset substantially the abnormal burden resulting from greater use and higher cost of health services required in old age, so as to give the aged a fair chance of maintaining their independence and providing for themselves.

(4) The public plan should be designed to encourage and facilitate coverage of the aged under private health insurance for additional protection. It is essential that health insurance coverage provided under the public and private plans be complementary and that the roles of the public and private sectors in providing protection be mutually reinforcing.

(5) The benefit structure of the public insurance plan should be focused upon health services, the cost of which tends to have the greatest and sharpest impact, rather than upon services involving routine costs or costs which tend to fall in a less concentrated fashion.

(6) The public insurance plan for the aged should fit into the current system of health facilities and medical care in the Nation, with maximum free choice among providers of services, and it should contribute to the improvement and expansion of needed health resources in the communities of the Nation.

(7) A fundamental long-range objective of the public insurance plan for the aged should be progressive improvement in the quality of the services financed through the plan.

(8) Responsibility for the administration of the public insurance plan for the aged should be assigned to the Secretary of Health, Education, and Welfare, with the assistance of an Advisory Council on Health Insurance for the Aged. In administering the plan, the Secretary should be authorized to contract for services of voluntary organizations and required to invite proposals from such

organizations for consideration. Direct administration of benefits should be undertaken by the Federal agency only if proposals from voluntary agencies are not adequate.

GUIDING PRINCIPLES OF COMPLEMENTARY PRIVATE INSURANCE

(1) As a corollary action to the establishment in the public sector of a plan for the aged limited to basic institutional services, national policy should assign to private insurance the complementary role of establishing protection to cover other health care requirements of aged persons.

(2) Private health insurance should concentrate primarily on covering the major clusters of expense for physician care and other noninstitutional services, so that, together with the institutional care covered by the public plan, the aged will have a well-balanced package of basic protection.

(3) Basic complementary protection under private insurance should be made available to all persons in the aged population without disqualifications, reductions in benefits, or increases in premiums because of advanced age or condition of health.

(4) Private insurance organizations should devote intensive efforts to extending basic complementary protection to the aged population, with concentration on developing marketing methods designed to produce high-volume, low-cost mass coverage.

(5) Congress should take action which would make it possible for insurance companies and nonprofit health plans to join in concerted nationwide efforts to extend to the aged population basic protection, complementary to that established under the public insurance plan for the aged.

(6) To increase the proportion of the aged covered in the future under complementary protection, private insurance organizations should develop methods for prepaying during the years of active employment the cost of health insurance in old age. Employed groups also should be encouraged to continue retirees under group insurance plans.

NATIONAL ADVISORY COUNCIL

A National Advisory Council on Health Insurance for the Aged should be created and charged with advising the Secretary in administering the public insurance plan for the aged and with making periodic reports to the Congress through the President on the status, in both the private and public sectors, of implementation of national policy for health care of the aged.

Senator JAVITS. Now, the main part of my statement is as follows, Mr. Chairman.

These hearings constitute a significant—perhaps even a historic—milestone in the provision of health care in the United States, and I am very pleased to have the opportunity to testify.

Since 1960, as I said, I have been working to establish a system of health care for the aged—and I have already recounted my connection with the establishment of this commitee, and its report.

I would like to also advert to the fact that this report, when completed, and I have it here, and I will include excerpts, was presented to former President Kennedy at the White House in November 1963, and at that time, the statement which he issued, was, in part, and I quote, "The report would be extremely helpful in our effort to obtain action in the Congress on this vital matter."

The main feature of this report was a plan for supplementary insurance covering those surgical and medical bills which were not included in the original hospitalization-through-social-security financing plan (King-Anderson). I believe this report served to call public attention to the inadequacies of the administration proposal—as it was standing alone—which at that time covered only hospital and limited home health services—an estimated 30 percent of health care services

required by the aged—but made no provision for insurance against medical bills.

The committee proposed that this latter feature be added in the form of a voluntary, supplementary insurance policy offered by existing carriers which would be contributory in form, would be offered on a nonprofit basis to every American over 65 and could be obtained for an estimated $2 per person per week. The Senate bill was passed on September 2, 1964, by a vote of 49 to 44, but the House of Representatives failed to act on it.

This year, essentially the same proposal—except that the sources of payment of the supplementary insurance premium, that is now a Federal contribution of $3—was made part of the bill which was reported by the House Ways and Means Committee, by our distinguished colleague, Congressman Mills, and which you have before you today. I support this bill, in substance, and particularly urge your favorable consideration of the supplementary feature which makes comprehensive health coverage possible for those over 65.

May I interject there, Mr. Chairman, and still within my time, that I am deeply disappointed with the insurance companies of the United States for not having come forward to take up the option which the Senate extended to them when it passed this bill and for not being before this committee today testifying to a plan which it will sponsor as part of this comprehensive health care proposal which is before the committee, and I think that the insurance companies really should give very earnest thought to this proposal before they let this go as it is, with the United States as the insurer.

Inevitably it will represent a difference, in their opportunity for business, which I think is unwise in terms of the private enterprise system and I would still urge them at this late date to take counsel with each other in terms of making themselves the insurers, and giving the American people the benefit, which Senator Anderson and I have always tried to get for them, of a complete private enterprise handling of the supplementary part of this effort rather than letting the Government be the insurer.

I realize that many will argue that it is nothing but a technical status for the Government, that the Government will then contract, as it does in health coverage for Government employees, with carriers of various kinds including Blue Cross, Blue Shield, GHI, and others but it is not the same thing as having the insurance companies take the basic responsibility.

I am very disappointed they haven't done so. I expressed that on the record and I still express the hope that they will realize what this means not only to their business, but to the private enterprise system generally and will yet come up with a plan in which they can take over the basic insurance themselves, even though the Government makes the contribution.

There is no reason why they should not be the fundamental insurers.

Mr. Chairman, I then continue.

There are, however, three areas in which I believe the bill needs to be amended, and I would like, briefly to bring them to the attention of the committee:

1. The Anderson-Gore-Javits bill had a provision under which the supplementary insurance coverage would include prescription drugs

and I call the attention of the committee to that section of our bill, S. 849, as it was introduced which was contained at section 101 of that bill, on page 10, lines 1 to 10, which contained a comprehensive definition of drugs which would be covered, and I ask unanimous consent to include that definition as part of the record.

Senator ANDERSON. Without objection, that will be done.

(The definition referred to follows:)

DEFINITION OF "DRUGS AND BIOLOGICALS"

The term "drugs" and the term "biologicals", except for purposes of subsection (c) (5) of this section, include only such drugs and biologicals, respectively, as are included in the "U.S. Pharmacopoeia," "National Formulary," "New and Non-Official Drugs," or "Accepted Dental Remedies," or are approved by the pharmacy and drug therapeutics committee (or the equivalent committee) of the medical staff of the hospital furnishing such drugs or biologicals (or of the hospital with which the skilled nursing facility furnishing such drugs or biologicals is affiliated or is under common control).

Senator JAVITS. This proposal, Mr. Chairman, was part of the report of the National Committee on Health Care for the Aged to which I have already referred and that report contemplated an insurance policy dealing not only with medical and surgical bills but also with certain other health care expenses of which the cost of drugs was a foremost item.

It has been estimated that 25 percent of the per capita health expenditure of aged persons is for drugs. On the average they spend more than twice as much for medicines as does the whole population. Nineteen States, including my own State of New York, include the cost of drugs as a covered expense in the Kerr-Mills program.

Now, the actuary's office in the Social Security Administration when asked what this would cost, that is, the inclusion of drugs, gave us an estimate that it would increase the cost of the supplementary policy in the pending bill by approximately $1.50 a month—half of which would be paid by the beneficial and the other half by the Government.

This appears to me to be a modest price for insurance against what is often a most burdensome expense, particularly in light of the fact that the cost to the subscriber will be more than covered by the contemplated 7 percent social security benefit increase which will provide a minium benefit increase of $4 a month.

The supplementary policy as contained in the House bill now would cost the beneficiary $3 a month and the addition of another 75 cents for drugs insurance would still be covered for many by even the minimum increase in his social security benefit.

I believe most older Americans would welcome the chance to purchase such coverage; with adequate control by the Secretary to preclude cost increases, this program could not only provide for coverage but in some instances where drug costs are a significant factor in treatment would I am sure make the difference between home treatment and expensive hospitalization, and it will be remembered, Mr. Chairman, that in the report which I filed with the Senate of a famous seminar at the College of Physicians and Surgeons on Health Care for the Aging, the main thrust of the recommendations of distinguished authorities in the geriatrics field was—

Keep them on their feet; keep them ambulatory and that is the most economical and most constructive way to deal with people over 65.

While medicine is a very, very important contribution to keeping the patient ambulatory just as medical care is, one of the big defects of the original administration bill was that in order to get drugs you had to go into the hospital.

Now, with this bill which the committee has before it, which contains the supplementary coverage, the older person is just as well off going to a doctor. His drug expenses are covered just the same, and that is very advantageous, and I point out that these relate to prescription drugs with a very specific definition which was contained in the bill that formerly passed the Senate.

The second point, Mr. Chairman, is that I would like to give my support to the amendment proposed by Senator Douglas to implement the services of radiologists and anesthesiologists, pathologists and other related specialists into the fundamental hospitalization aspect of the bill as advocated by Senator Douglas, of Illinois, who is sponsoring that amendment.

The third pont relates to the improvement in the Kerr-Mills program which sets a deadline of July 1, 1970, after which all non-Federal money used for medical assistance to the indigent must come from State sources as distingiushed from subdivisions, political subdivisions of each State.

In New York, as in a number of other States which have acted under the Kerr-Mills program, the non-Federal share has been divided bebetween the States and local welfare boards. This is a pattern common to many matching programs and I believe it is an equitable formula.

At the very least each State shall be allowed to determine how its non-Federal share is raised, whether entirely from the State treasury, entirely from local sources, or, as in New York, from contributions of both.

Mr. Chairman, as to items 1 and 3 in my presentation, I will submit to the committee the text of amendments which I recommend.

Now, the only other point I would like to raise is that the Public Health Association has approached me, as it has approached other members, with various recommendations which ought to go into this bill.

I believe that most of the things that they legitimately would want have been taken care of, to wit, the matter of the specialists like radiologists, which is covered by Senator Douglas' amendments and this will be voted up or down by the committee. Their other suggestion is that local health departments as well as local welfare agencies should have the opportunity to administer this bill, depending upon the views of each State, and we have checked the bill carefully, and that appears to be in the bill.

We have a feeling that the Public Health Association may want to make it mandatory for State and local health agencies to handle this. I can't go along with that. I think the option is the right way to do it and that is apparently now contained in the bill.

They also asked some guarantee that charges made to patients for services rendered by doctors will be only those that are paid from the funds generated by this bill, and I will look into that carefully and if I think it rates an amendment I will submit one to the committee.

Finally, Mr. Chairman, I ask unanimous consent that at a later date I may file a statement with the committee and the text of any

amendments which I believe ought to be proposed to the social security aspects of this bill as distinguished from that part which deals with medical care for the aging.

Senator ANDERSON. Without objection that will be done.

Senator Williams, do you have any questions?

Senator WILLIAMS. No questions, except to say, Senator Javits, that we are delighted to have you here this morning and testify on this bill. The point that you raised about the bill allowing the States the choice as to whether the Public Welfare or the Public Health Service shall handle this program is well taken. The objections we have had raised before this committee are that the bill does not spell out this authority quite clearly enough.

I think it was intended that the States have this choice, and I agree with you that they should have the choice.

However, we have had several representatives from both welfare agencies and the other departments, too, raising a question as to whether the language is clear in the bill.

Senator JAVITS. Well, Mr. Chairman, if I may have permission to do so, and I have given the Senate some legal services before, I will look it over very carefully, and if in my judgment as a lawyer, it can be tightened up, I will take the privilege, if the Chair will allow me to submit an amendment.

Senator ANDERSON. Surely.

As I understand it, Mr. Mills made a statement or the committee report made a statement that certain things were done. Then people examining the bill found another section of the bill that seemed to direct something else. One of the great problems where you are drafting legislation is that you can't plug all loopholes at the same time and that is the main question, we find in the testimony here before us people thought it did certain things, found it did not, thought it ought to be resolved.

And I appreciate the offer of the Senator from New York to look at it.

Senator JAVITS. I am sure you have other lawyers doing the same thing but if I can be of any help I will help.

Senator ANDERSON. Senator Carlson?

Senator CARLSON. Only this. I appreciate the Senator's appearance before this committee. He has not only been dedicated to this type of program for years, he has been diligent in trying to secure approval and he has made some suggestions this morning that will be very helpful to the committee.

I appreciate very much your appearance.

Senator JAVITS. Thank you so much.

Senator ANDERSON. Thank you very much, Senator Javits.

We are happy to have you here.

Dr. Stokes?

STATEMENT OF DR. J. BUROUGHS STOKES, MANAGER, WASHINGTON, D.C., OFFICE, CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION OF THE FIRST CHURCH OF CHRIST, SCIENTIST

Dr. STOKES. Mr. Chairman and members of the committee, my name is J. Buroughs Stokes. I am a manager of the Washington, D.C.,

office, Christian Science Committee on Publication of the First Church of Christ, Scientist, in Boston, Mass. The Christian Science board of directors, the administrative head of the Christian Science denomination, has authorized my appearance before you.

H.R. 6675, the Social Security Amendments of 1965, as passed by the House of Representatives, defines the term "hospital" to include Christian Science sanatoriums (sec. 1861(e), p. 67, lines 9–18), thus offering a type of benefits which Christian Scientists could accept, and with which we strongly support, in lieu of the inpatient hospital benefits available to other citizens.

However, we believe the House inadvertently overlooked including similar provision with respect to Christian Science nursing homes and Christian Science visiting nurse services, and, accordingly, we respectfully submit for your consideration the following two technical amendments designed to correct this apparent oversight:

Re nursing homes, page 74, line 3, add the following:

The term "extended care facility" also includes an institution (or a distinct part of an institution) which is operated, or listed and certified, as a Christian Science nursing home by the First Church of Christ, Scientist, in 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.

Re visiting nurse services, page 81, line 3, add the following:

The term "home health agency" also includes a Christian Science visiting nurse service operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such service to individuals, and payment may be made with respect to services provided by such service 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.

While these amendments are of a minor nature when viewed in the context of the entire bill, they are of major importance to Christian Scientists throughout the country. Inclusion of these amendments within the present bill would be consistent with recognition already afforded us under other Federal laws such as the Federal Employees Health Benefits Act, and so forth.

Your courtesy in according us the privilege of making this presentation is appreciated.

Senator ANDERSON. Dr. Stokes, so that we might have some background to know what we are dealing with in the way of a problem, how many persons are there in Christian Scientists nursing homes now?

Dr. STOKES. I don't have that figure.

Senator ANDERSON. Will you supply us with the figure of how many are in Christian Scientists nursing homes, how many are aged, about how long they stay in these homes, what is generally wrong with them, what treatments they receive, and how many are discharged from those institutions as a result of the treatment received.

Will you give us some background on that?

Dr. STOKES. I will try to do that. As I have testified on this subject four times before I didn't wish to take the time of the committee to give you more today.

Senator ANDERSON. I appreciate that. It just so happens I don't have any idea how many Christian Scientist nursing homes there are.

Dr. STOKES. Yes, sir.

Senator ANDERSON. I would like to know it. I would like to know whether the Christian Scientist nursing homes would involve any religious counseling.

Dr. STOKES. Yes, sir.

Senator ANDERSON. As I understand it the Christian Scientist nursing homes have a lot of aged persons. We would like to know later on what services the sanatoriums offer which are now provided in nursing home care and if you can furnish that information we can make an intelligent appraisal of your request.

Dr. STOKES. Yes, sir.

(The information referred to follows:)

CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION,
OF THE FIRST CHURCH OF CHRIST, SCIENTIST, IN BOSTON, MASS.,
Washington, D.C., May 18, 1965.

Re H.R. 6675, Social Security Amendments of 1965.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: In accordance with the request of the Senate Finance Committe on May 12, 1965, when I testified on H.R. 6675, the following information relative to Christian Science sanatoriums, nursing homes, and nursing services is respectfully submitted.

It is necessary in order for you to evaluate properly this material to explain briefly that Christian Science is a religion based on the words and works of Christ Jesus. It relies solely on spiritual means for healing as did the Master. This healing is the result of prayer; it never has included, or does include, medication or surgery. Healing by prayer as understood and practiced in Christian Science has been tested before the public for nearly 100 years. During that time a great body of evidence as to its efficacy in healing every sort of disease has been established, including numerous healings of organic as well as functional disease, of malignancies, pronounced fatal by competent medical authorities, as well as of obviously neurasthenic disorders. Many of the cases have long medical histories behind them; in many instances the expert diagnoses made before the patient turned to Christian Science for healing have been supported by X-ray examinations, microscopic tests, and so forth. In a number of cases the healings have been instantaneous, or so rapid as to rule out any theory of the "natural recuperative powers of the human organism." Not infrequently, doctors who have observed these healings have stated frankly that only God could have wrought them.

As a healing system, Christian Science is the antipode of the medical. In fact, there is no way to equate the two. The only thing they have in common is their healing objective. To heal by spiritual means, one must look away from the body to God—divine truth and love—the source of man's health and true being. Spiritual healing therefore does not require medical examinations and diagnoses, nor are any records kept by a Christian Science practitioner, patient or sanatorium as to the patient's physical condition, as would be done under a medical system.

Although Christian Scientists do not use medical methods, they do not ignore or neglect human ailments, diseases or injuries. On the contrary, healing the sick and maintaining physical health through spiritual means is for them a matter of religious conviction and practice. In fact, the Christian Science Church accredits a list of Christian Science practitioners and nurses and certifies Christian Science sanatoriums, etc., to which individuals confronted with sickness and disability may turn for treatment and care, much as the non-Christian Scientist would employ the services of medical doctors, nurses, and hospitals under similar circumstances.

Most healings in Christian Science are quickly accomplished by a Christian Science practitioner in his office or during a home call. Unlike those under

medicine, a Christian Scientist does not go on the slightest provocation to a sanatorium for treatment, but only in cases of acute need where 24-hour nursing care and attention are required. This is well illustrated by the facts revealed in the enclosed table (see enclosure A). For the countless thousands who rely upon Christian Science for health care there were, as of May 14, 1965, on actual tabulation, only 250 patients in our sanatoriums throughout the United States. Again, as you may note from enclosure A, there are only 17 sanatoriums in this country, 2 maintained by the church and the others privately run, after meeting accreditation requirements of the Committee on Care for Christian Scientists of the First Church of Christ, Scientist, in Boston, Mass.

Like all other religious organizations, we are deeply concerned over the problem of health care for the aged, and want to do all we possibly can to assist in a program such as outlined in H.R. 6675. In this we have set up the Committee on Care for Christian Scientists, and have established standards for—

Christian Science sanatoriums (see enclosure B),
Christian Science nursing homes (see enclosure C),
Christian Science rest homes (see enclosure D),
Christian Science visiting nurse services (see enclosure E),

all of which are required to comply with State fire, safety, and sanitary regulations.

The questions given to us by your committee on May 12 are answered herewith as honestly and as fully as possible.

1. *Christian Science sanatoriums.*—There are seventeen Christian Science sanatoriums in the United States certified by the First Church of Christ, Scientist, in Boston, Mass. Until recently, these institutions have been available for Christian Scientists with all types of illnesses, major or minor, with the exception of contagious and maternity cases. Under the Committee on Care for Christian Scientists, which was organized in July 1964, however, sanatoriums will henceforth be designated only for the care of patients who would be confined in a hospital if they were not relying entirely on Christian Science for healing.

To gain admission to a sanatorium, an individual must be receiving treatment from a Christian Science practitioner listed in the Christian Science Journal, the official organ of our church, and must be, in the opinion of the practitioner, unable to take physical care of himself as a result of an acute condition and in need of intensive Christian Science nursing care in conjunction with daily Christian Science treatment. Admission is certified only after—

1. Personal application by the patient.
2. Verification of need for Christian Science sanatorium care by the listed Christian Science practitioner on the case.
3. Approval of application by Admission and Utilization Review Committee of the sanatorium, and verification of need.
4. Engagement of a local Christian Science practitioner by the patient for treatment.

The Admission and Utilization Review Committee consists of at least two persons, such as the manager of the institution, head nurse, or supervisor of admissions, under the system in use for the past 45 years in the Christian Science Benevolent Associations.

Christian Science as a healing method cannot be scientifically compared to medicine using medical standards because Christian Scientists do not diagnose medically. However, a Christian Scientist knows when he is very sick or bedfast just as well as any other individual, and we believe that the standards for establishing a need for sanatorium care outlined above are adequate to exclude the senile, recuperatives, malingerers, hypochondriacs, and persons only moderately ill.

At present there are 250 persons in Christian Science sanatoriums. The appended table (see enclosure A) will give you some facts concerning the patients over 65, such as number of cases, and average length of stay. It is safe to say that virtually every major disease and physical disability has been treated and healed while individuals were patients at these sanatoriums. For instance, the Christian Science Benevolent Association at Chestnut Hill, Mass., reports healings during the past year of broken limbs, broken pelves, all without surgery; cerebral thrombosis; stroke; paralysis; ulcers; cancer, to name but a few, all of which had been diagnosed medically prior to admission to the sanatorium.

It may interest your committee to know that for years, private insurance companies have provided hospitalization benefits to Christian Scientists in their

sanatoriums under the same conditions, and at the same premiums, as persons who use medical hospitals. Among these companies are the following:

The Aetna Life Insurance Co.
The Aetna Casualty and Surety Co.
Connecticut General Life Insurance Co.
Washington National Life Insurance Co.
New York Life Insurance Co.
Nationwide Insurance Co.
The Travelers Insurance Co.
United Pacific Insurance Co.
The Metropolitan Life Insurance Co.
Continental Casualty Co.'s Golden 65.
Massachusetts 65.
Connecticut 65.

Christian Science nursing homes.—The Committee on Care for Christian Scientists is in the process of reorganizing and reexamining the system of Christian Science nursing homes. At present, there are about 50 of such homes which might qualify for accreditation by this committee.

Christian Science visiting nurse service.—The Christian Science visiting nurse service (enclosure E) is our fastest growing facility. It provides nursing care for Christian Scientists in the patient's home on an hourly basis. At present, this service is established in 88 areas throughout the United States. The nurses who offer this service are graduates of an approved Christian Science nurses training course, and must be listed in the current issue of The Christian Science Journal. They provide nursing service on an intermittent basis.

2. The above-described admission requirements will exclude individuals who, although unable to care for themselves, are not in need of healing. The Christian Science practitioner and the Admissions and Utilization Review Committee examining each case will eliminate cases where no rehabilitation or restoration is needed.

There are a number of Christian Science institutions, commonly referred to as nursing homes, which do give only personal health care on a long-term basis. However, none of these institutions would be eligible to provide services under H.R. 6675.

3. The Christian Science nurse is equipped to give skilled nursing care and execute procedures requiring training, judgment, knowledge, and skills beyond those which the untrained possess. Since it is the Christian Science practitioner, and not the nurse, who provides the curative treatment, the Christian Science nurse is specifically instructed not to interfere with or supplant the practitioner. The only nursing activity which approximates religious counseling might be the reading of religious matter to a patient unable to read by himself, much as a medical nurse might read to a blind patient in a medical nursing home. Christian Science nurses are trained to assist in physical needs which attend a healing such as changing bandages and teaching patients how to walk again, etc.

4. Christian Science sanatoriums perform services that are, to a degree, similar to those in personal care nursing homes, since their patients do not seek healing through the orthodox methods used in hospitals. The distinction between sanatoriums and personal care nursing homes is found not in the services provided, but by the physical needs of the patients. Sanatorium patients are suffering from diseases which would require hospital care if they were not Christian Scientists; personal care nursing home patients do not require the same skilled professional attention. The cost of room, board and nursing care for a patient in a medical hospital are included in his hospital bill. In a Christian Science sanatorium such costs are also in the bill. In our sanatoriums, however, all the other elements of a hospital bill—i.e., X-rays, drugs, biologicals, laboratory analyses, etc.—are not present, because they have no part in Christian Science healing. Those unfamiliar with the health practices in a Christian Science sanatorium sometimes assume that they function somewhat along the lines of personal care nursing homes, which is definitely not the case.

5. Christian Science institutions admit only patients who are under the care of Christian Science practitioners exclusively. Patients relying upon medical care in any form are not accepted. It is not correct to supplement Christian Science with medical care since they are mutually exclusive systems.

Under H.R. 6675, individuals are entitled to limited benefits from "hospitals," "extended care facilities" and "home health agencies" during a "single spell of illness." The inclusion of Christian Science institutions within these defini-

tions could not expand the length of stay or change the meaning of "spell of illness" to permit tacking a stay in one institution to the end of another.

The foregoing facts may appear surprising to one not familiar with Christian Science, but I can assure you that spiritual care and treatment is known to be a safe, effective therapeutic system—so much so, that Christian Science is practiced freely and without legal restriction in every State of the Union. Furthermore, today hundreds of insurance companies in the United States recognize and pay for Christian Science treatment and care in their group insurance agreements and their various casualty and accident lines. In the insurance field, claims by Christian Scientists usually are paid as quickly and efficiently as those of non-Christian Scientists. The facts that Christian Science treatment and care are established on a definite basis, that thoroughly documented records of healings extend over many years, and that Christian Scientists are reasonable and law-abiding people, have had considerable influence on the recognition afforded us by insurance companies.

Because of this recognition and realizing that the Department of Health, Education, and Welfare, and those charged with the immediate administration of H.R. 6675, if enacted into law, would be hard pressed to understand and gather statistics and facts on our religious system of healing, we proposed to the House Committee on Ways and Means in February 1965, an amendment providing for a restricted cash option. Briefly, this would have provided that anyone who had conscientious objection against utilizing the medically oriented services and care enumerated in the bill, and who was included in a qualified private health insurance benefit plan, would have been entitled to a monthly cash payment; the payment to which the individual would be entitled to be made to the appropriate insurance company by which such individual is covered if the individual filed with the Secretary of Health, Education, and Welfare a statement designating the approved insurance carrier. We were confident this provision could have been easily administered, and would have allowed for a scope of benefits broad enough to benefit all of our senior citizens, and would definitely have been in keeping with the intent of the Congress that this type of legislation be extended to all individuals, regardless of race, creed, color, and religious beliefs.

May we assure you, however, that, if this piece of legislation is finally enacted into law, the First Church of Christ, Scientist, in Boston, Mass., and our adherents, will cooperate honestly and sincerely with its administration.

In the event we can be of further assistance, please do not hesitate to call this office.

Respectfully,

J. BURROUGHS STOKES,
Manager, Washington, D.C. Office.

ENCLOSURE A

Data on Christian Science Sanatoriums (requested by Finance Committee, U.S. Senate on May 12, 1965, in connection with hearings on H.R. 6675)

Sanatoriums	Number of patients in institution			Number working out acute conditions			Average number of days spent in institution		
	Over 65	Under 65	Total	Over 65	Under 65	Total	Over 65	Under 65	Average
Broadview, Los Angeles, Calif.	17	4	21	12	4	16	------	------	20
Sunland Home, San Diego, Calif.	7	0	7	1	0	1	21	8	15
Christian Science Benevolent Association, San Francisco, Calif.	18	5	23	11	3	14	34	27	32
Wide Horizon, Wheat Ridge, Colo.	11	0	11	7	0	7	9	0	9
Morningside, St. Petersburg, Fla.	9	2	11	4	2	6	25	24	25
Hill Top Farm, Lake Bluff, Ill.	4	1	5	4	0	4	------	------	24
Christian Science Benevolent Association, Chestnut Hill, Mass.	26	9	35	15	5	20	41	20	30
Concord, Detroit, Mich.	7	9	16	7	9	16	22	19	20
Great Oaks, Kansas City, Mo.	6	0	6	4	0	4	33	6	20
Newhaven, Puyallup, Wash.[1]	43	6	49	14	0	14	------	------	17
Peace Haven, St. Louis, Mo.	9	0	9	6	0	6	10	45	28
Tenacre, Princeton, N.J.[1]	6	3	9	3	2	5	54	------	54
High Ridge House, Westchester County, N.Y.	5	1	6	3	0	3	38	30	34
Overlook House, Cleveland, Ohio	10	3	13	3	1	4	55	65	60
High Oaks, Philadelphia, Pa.	6	1	7	4	1	5	27	29	28
Sunrise House, Seattle, Wash.	8	5	13	6	2	8	42	15	35
Clearview Home, Delafield, Wis.	5	4	9	4	5	9	------	------	22
Total (17)	197	53	250	108	34	142	------	------	------

[1] Only two institutions equipped to handle cases with mental disorders, Tenacre Foundation, Princeton, N.J., and Newhaven, Inc., Puyallup, Wash.

Christian Science treatment is solely by prayer or spiritual means. No medication.

NOTE.—Our sanatoriums accept all types of cases which normally would require hospital care.

ENCLOSURE B

CHRISTIAN SCIENCE SANATORIUMS

Committee on Care for Christian Scientists, the First Church of Christ, Scientist, Boston, Mass.

POLICY OF THE CHRISTIAN SCIENCE BOARD OF DIRECTORS RESPECTING NURSING CARE FOR CHRISTIAN SCIENTISTS

1. That nursing the sick under Christian Science care is an important part of the healing ministry of Christian Science. See Article VIII, Section 31, of the Manual of The Mother Church by Mary Baker Eddy.

2. That (*a*) sanatoriums, (*b*) nursing homes, (*c*) rest homes and homes providing special attention where nursing service is available, and (*d*) visiting nurse services are recognized as appropriate and helpful means in providing proper nursing care for Christian Scientists. Their purpose is to support the healing activity of Christian Science.

3. That such facilities when publicly identified as being operated by and for Christian Scientists be organized, operated, and maintained in accordance with standards established by this Board in order to be eligible for accreditation by The Mother Church.

4. That such facilities be managed and financed on a local or area basis and, where practicable, all related services in a given locality be under the direction of one governing board.

5. That consultation and guidance to those who are interested in planning or organizing or who are presently operating such facilities be available from the Committee on Care for Christian Scientists.

6. That the Committee on Care for Christian Scientists be authorized to receive applications for and to issue certificates of accreditation to such facilities as it finds after inspection to be organized, operated, and maintained all in accordance with prescribed standards. Residential homes for those of advancing years shall not be eligible for accreditation.

THE CHRISTIAN SCIENCE BOARD OF DIRECTORS.

STANDARDS ESTABLISHED BY THE CHRISTIAN SCIENCE BOARD OF DIRECTORS FOR CHRISTIAN SCIENCE SANATORIUMS

1. Definition

The term "sanatorium" as used herein means a facility or unit, however named, which is designated, staffed, and equipped for the care of patients who would be confined in a hospital if they were not relying entirely on Christian Science for healing. Only spiritual means; that is, prayer, shall be employed therein for healing. The care and related services shall be performed under the directions of persons qualified to provide such care and services. The sanatorium shall be operated in accordance with the laws of the state in which the facility is located.

2. Organization Pattern

Sanatoriums for those relying entirely on Christian Science may be organized on a nonprofit or a profit basis. Such facilities shall have a Board of Trustees or a Board of Directors who shall be responsible for the overall administration of the sanatorium. Persons serving on such Boards shall be available and in regular attendance at Board meetings. All such Trustees and Directors shall be acceptable to The Christian Science Board of Directors.

3. License

The operation of a Christian Science sanatorium is a religious activity. It should not be licensed except insofar as a license may be required in compliance with fire, safety, and sanitation regulations.

4. Financial Responsibility

The Trustees or Directors shall give evidence of the financial responsibility of the sanatorium.

5. Administration

The administrator of a sanatorium shall be qualified by training or experience. He shall be responsible directly to the Trustees or Directors for the maintenance and operation of the sanatorium and its compliance with all current standards.

It is the responsibility of the administrator to coordinate the efforts of all sections within the sanatorium and to maintain an efficient administration thereof. He shall act as liaison between the Trustees or Directors and the staff.

Staff employed by the sanatorium shall have qualifications and training commensurate with the duties assigned. All employees must be found to be fit and proper by the Committee on Care for Christian Scientists.

6. Church membership

All Trustees, Directors, administrators, and key personnel shall be members of The Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts, and one of its branches. Only membership in The Mother Church is required of nurses.

7. Physical plant and equipment

The physical plant, which shall conform to all code and zoning requirements for buildings used for sanatoriums, and all equipment shall be maintained in a good state of repair.

All fire, safety, and sanitation requirements shall be fully met and clearance therefor obtained from the proper authorities.

8. Eligibility and treatment

To be eligible for admission to a sanatorium, a patient shall be under treatment by a Christian Science practitioner listed in the current issue of The Christian Science Journal, and shall continue under such treatment during his entire stay.

9. Nursing staff

The sanatorium administrator is responsible to see that skilled nursing care is available for all patients on a 24-hour basis. Christian Science nursing service shall be supervised by a graduate of an approved Christian Science nurses' training course and be listed in the current issue of The Christian Science Journal.

10. Rates

The charges or rates of a sanatorium shall be filed with the Committee on Care for Christian Scientists.

11. Food preparation and serving

Food served shall be of good quality and suitable variety and shall be prepared and served in such a way as to protect its quality and palatability.

12. Record keeping

Proper records and books of account as may be required or needed shall be kept.

The books of the sanatorium shall be audited annually by a certified public accountant.

13. Operation

A sanatorium at all times shall operate in accordance with these standards and such other requirements as are now or may hereafter be established by this Board.

Information and assistance are available from Committee on Care for Christian Scientists, 107 Falmouth Street, Boston, Mass.

ENCLOSURE C

CHRISTIAN SCIENCE NURSING HOMES—COMMITTEE ON CARE FOR CHRISTIAN SCIENTISTS, THE FIRST CHURCH OF CHRIST, SCIENTIST, BOSTON, MASS.

POLICY OF THE CHRISTIAN SCIENCE BOARD OF DIRECTORS RESPECTING NURSING CARE FOR CHRISTIAN SCIENTISTS

1. That nursing the sick under Christian Science care is an important part of the healing ministry of Christian Science. See Article VIII, Section 31, of the Manual of The Mother Church by Mary Baker Eddy.

2. That (*a*) sanatoriums, (*b*) nursing homes, (*c*) rest homes and homes providing special attention where nursing service is available, and (*d*) visiting nurse services are recognized as appropriate and helpful means in providing proper nursing care for Christian Scientists. Their purpose is to support the healing activity of Christian Science.

3. That such facilities when publicly identified as being operated by and for Christian Scientists be organized, operated, and maintained in accordance with standards established by this Board in order to be eligible for accreditation by The Mother Church.

4. That such facilities be managed and financed on a local or area basis and, where practicable, all related services in a given locality be under the direction of one governing board.

5. That consultation and guidance to those who are interested in planning or organizing or who are presently operating such facilities be available from the Committee on Care for Christian Scientists.

6. That the Committee on Care for Christian Scientists be authorized to receive applications for and to issue certificates of accreditation to such facilities as it finds after inspection to be organized, operated, and maintained all in accordance with prescribed standards. Residential homes for those of advancing years shall not be eligible for accreditation.

THE CHRISTIAN SCIENCE BOARD OF DIRECTORS.

STANDARDS ESTABLISHED BY THE CHRISTIAN SCIENCE BOARD OF DIRECTORS FOR CHRISTIAN SCIENCE NURSING HOMES

1. Definition

The term "nursing home" as used herein means a facility or unit, however named, which is designated, staffed, and equipped for the accommodation of individuals relying entirely on Christian Science, in need of nursing care and related services, but not requiring the degree of care given in an accredited Christian Science sanatorium. Only spiritual means, that is, prayer, shall be employed therein for healing. Such services shall be performed under the directions of persons qualified to provide such care or services. The nursing home shall be operated in accordance with the laws of the state in which the facility is located.

2. Organization pattern

Nursing homes for those relying entirely on Christian Science may be organized on a nonprofit or a profit basis. Incorporated facilities shall have a Board of Trustees or a Board of Directors which shall be responsible for the overall administration of the nursing home. Persons serving on such Boards shall be available and in regular attendance at Board meetings. A trusteeship, copartnership, or an individual may also establish a nursing home for profit. All such Trustees, Directors, copartners, and individuals shall be acceptable to The Christian Science Board of Directors.

3. License

The operation of a Christian Science nursing home is a religious activity. It should not be licensed except insofar as a license may be required in compliance with fire, safety, and sanitation regulations.

4. Financial responsibility

The Trustees, Directors, copartners, or individuals shall give evidence of the financial responsibility of the nursing home.

5. Administration

The administrator or operator of a nursing home shall be qualified by training or experience. He shall be responsible for the maintenance and operation of the nursing home and its compliance with all current standards. It is the responsibility of the administrator or operator to coordinate the efforts of all sections within the nursing home and to maintain an efficient administration thereof.

Staff employed by the nursing home shall have qualifications and training commensurate with the duties assigned. All employees must be found to be fit and proper by the Committee on Care for Christian Scientists.

6. Church membership

All Trustees, Directors, copartners, individual owners, and key personnel shall be members of The Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts, and one of its branches. Only membership in The Mother Church is required of nurses.

7. Physical plant and equipment

The physical plant, which shall conform to all code and zoning requirements for buildings used for nursing homes, and all equipment shall be maintained in a good state of repair.

All fire, safety, and sanitation requirements shall be fully met and clearance therefor obtained from the proper authorities.

8. Eligibility and treatment

To be eligible for admission to a nursing home, a patient shall be under treatment by a Christian Science practitioner listed in the current issue of The Christian Science Journal.

9. Nursing staff

The nursing home administrator is responsible to see that adequate nursing care is available for all patients. Christian Science nursing service shall be supervised by a nurse listed in the current issue of The Christian Science Journal.

10. Rates

The charges or rates of a nursing home shall be filed with the Committee on Care for Christian Scientists.

11. Food preparation and serving

Food served shall be of good quality and suitable variety and shall be prepared and served in such a way as to protect its quality and palatability.

12. Recordkeeping

Proper records and books of account as may be required or needed shall be kept.

The books of the nursing home shall be audited annually by a certified public accountant.

13. Operation

A nursing home at all times shall operate in accordance with these standards and such other requirements as are now or may hereafter be established by this Board.

Information and assistance are available from Committee on Care for Christian Scientists, 107 Falmouth Street, Boston, Mass.

ENCLOSURE D

REST HOMES AND HOMES PROVIDING SPECIAL ATTENTION FOR CHRISTIAN SCIENTISTS WHERE NURSING SERVICE IS AVAILABLE

Committee on Care for Christian Scientists, the First Church of Christ, Scientist, Boston, Mass.

POLICY OF THE CHRISTIAN SCIENCE BOARD OF DIRECTORS RESPECTING NURSING CARE FOR CHRISTIAN SCIENTISTS

1. That nursing the sick under Christian Science care is an important part of the healing ministry of Christian Science. See Article VIII, Section 31, of the Manual of The Mother Church by Mary Baker Eddy.

2. That (*a*) sanatoriums, (*b*) nursing homes, (*c*) rest homes and homes providing special attention where nursing service is available, and (*d*) visiting nurse services are recognized as appropriate and helpful means in providing proper nursing care for Christian Scientists. Their purpose is to support the healing activity of Christian Science.

3. That such facilities when publicly identified as being operated by and for Christian Scientists be organized, operated, and maintained in accordance with standards established by this Board in order to be eligible for accreditation by The Mother Church.

4. That such facilities be managed and financed on a local or area basis and, where practicable, all related services in a given locality be under the direction of one governing board.

5. That consultation and guidance to those who are interested in planning or organizing or who are presently operating such facilities be available from the Committee on Care for Christian Scientists.

6. That the Committee on Care for Christian Scientists be authorized to receive applications for and to issue certificates of accreditation to such facilities as it finds after inspection to be organized, operated, and maintained all in accordance with prescribed standards. Residential homes for those of advancing years shall not be eligible for accreditation.

THE CHRISTIAN SCIENCE BOARD OF DIRECTORS

STANDARDS ESTABLISHED BY THE CHRISTIAN SCIENCE BOARD OF DIRECTORS FOR REST HOMES AND HOMES PROVIDING SPECIAL ATTENTION FOR CHRISTIAN SCIENTISTS WHERE NURSING SERVICE IS AVAILABLE

1. Definition

The term "rest home" or "home providing special attention" as used herein means a facility or unit, however named, which is designated, staffed, and equipped for the accommodation of adults or children relying entirely on Christian Science, in need of light nursing care from time to time and related services, but not requiring the degree of care given in an accredited Christian Science nursing home. Only spiritual means, that is, prayer, shall be employed therein for healing. Such services shall be performed under the direction of persons qualified to provide such care or services. The home shall be operated in accordance with the laws of the state in which the facility is located. Residential homes for those of advancing years shall not be eligible for accreditation.

2. Organization pattern

Rest homes or homes providing special attention for those relying entirely on Christian Science may be organized on a nonprofit or a profit basis. Incorporated facilities shall have a Board of Trustees or a Board of Directors which shall be responsible for the overall administration of the rest home or home providing special attention. Persons serving on such Boards shall be available and in regular attendance at Board meetings. A trusteeship, copartnership, or an individual may also establish a rest home or home providing special attention for profit. All such Trustees, Directors, copartners, and individuals shall be acceptable to The Christian Science Board of Directors.

3. License

The operation of a rest home for Christian Scientists or a home providing special attention for Christian Scientists is a religious activity. It should not be licensed except insofar as a license may be required in compliance with fire, safety, and sanitation regulations.

4. Financial responsibility

The Trustees, Directors, copartners, or individuals shall give evidence of the financial responsibility of the rest home or home providing special attention.

5. Administration

The administrator or operator of a rest home or home providing special attention shall be qualified by training or experience. He shall be responsible for the maintenance and operation of the home and its compliance with all current standards. It is the responsibility of the administrator or operator to coordinate the efforts of all sections within the home and to maintain an efficient administration thereof.

Staff employed by the home shall have qualifications and training commensurate with the duties assigned. All employees must be found to be fit and proper by the Committee on Care for Christian Scientists.

6. Church membership

All Trustees, Directors, copartners, individual owners, and key personnel shall be members of The Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts, and one of its branches. Only membership in The Mother Church is required of nurses.

7. Physical plant and equipment

The physical plant, which shall conform to all code and zoning requirements for buildings used for rest homes and homes providing special attention, and all equipment shall be maintained in a good state of repair.

All fire, safety, and sanitation requirements shall be fully met and clearance therefor obtained from the proper authorities.

8. Eligibility and treatment

To be eligible for admission to a rest home or home providing special attention, a guest must be an adherent of the teachings of Christian Science and depend solely on Christian Science for healing.

9. Nursing staff

The administrator of a rest home or home providing special attention is responsible to see that adequate nursing service is available for all patients. Christian Science nursing service shall be performed by Christian Science nurses who at least have had five years' practical experience in Christian Science nursing.

10. Rates

The charges or rates of such homes shall be filed with the Committee on Care for Christian Scientists.

11. Food preparation and serving

Food served shall be of good quality and suitable variety and shall be prepared and served in such a way as to protect its quality and palatability.

12. Record keeping

Proper records and books of account as may be required or needed shall be kept.

The books of the rest home or home providing special attention shall be audited annually by a public accountant.

13. Operation

A rest home or home providing special attention at all times shall operate in accordance with these standards and such other requirements as are now or may hereafter be established by this Board.

Information and assistance are available from Committee on Care for Christian Scientists, 107 Falmouth Street, Boston, Mass.

ENCLOSURE E

CHRISTIAN SCIENCE VISITING NURSE SERVICES

Committee on Care for Christian Scientists, the First Church of Christ, Scientist, Boston, Mass.

POLICY OF THE CHRISTIAN SCIENCE BOARD OF DIRECTORS RESPECTING NURSING CARE FOR CHRISTIAN SCIENTISTS

1. That nursing the sick under Christian Science care is an important part of the healing ministry of Christian Science. See Article VIII, Section 31, of the Manual of The Mother Church by Mary Baker Eddy.

2. That (*a*) sanatoriums, (*b*) nursing homes, (*c*) rest homes and homes providing special attention where nursing service is available, and (*d*) visiting nurse services are recognized as appropriate and helpful means in providing proper nursing care for Christian Scientists. Their purpose is to support the healing activity of Christian Science.

3. That such facilities when publicly identified as being operated by and for Christian Scientists be organized, operated, and maintained in accordance with standards established by this Board in order to be eligible for accreditation by The Mother Church.

4. That such facilities be managed and financed on a local or area basis and, where practicable, all related services in a given locality be under the direction of one governing board.

5. That consultation and guidance to those who are interested in planning or organizing or who are presently operating such facilities be available from the Committee on Care for Christian Scientists.

6. That the Committee on Care for Christian Scientists be authorized to receive applications for and to issue certificates of accreditation to such facilities as it finds after inspection to be organized, operated, and maintained all in accordance with prescribed standards. Residential homes for those of advancing years shall not be eligible for accreditation.

THE CHRISTIAN SCIENCE BOARD OF DIRECTORS.

STANDARDS ESTABLISHED BY THE CHRISTIAN SCIENCE BOARD OF DIRECTORS FOR CHRISTIAN SCIENCE VISITING NURSE SERVICES

1. Definition

The term "visiting nurse service" as used herein means a service which provides Christian Science nursing care on an hourly basis to those relying entirely on Christian Science for healing.

2. Organization Pattern

Visiting nurse services for those relying entirely on Christian Science for healing shall be organized on a nonprofit basis. Such services shall have a Board of Trustees who shall be responsible for the overall administration of the service. Persons serving on such Boards shall be available and in regular attendance at Board meetings. All such Trustees shall be acceptable to The Christian Science Board of Directors.

3. Financial Responsibility

The Trustees of a visiting nurse service shall give evidence of the financial responsibility of the service.

4. Administration

The Trustees shall be responsible for the maintenance and operation of the visiting nurse service and its compliance with all current standards.

5. Church Membership

All Trustees and staff shall be members of The Mother Church, The First Church of Christ, Scientist, in Boston, Mass., and one of its branches. Only membership in The Mother Church is required of nurses.

6. Eligibility for Nursing Service

A patient must be an adherent of the teachings of Christian Science and depend solely on Christian Science for healing.

7. Nursing Staff

The visiting nurse shall be a graduate of an approved Christian Science nurses' training course and be listed in th current issue of The Christian Science Journal.

8. Record Keeping

Proper records and books of account as may be required or needed shall be kept.

The books of a visiting nurse service shall be audited annually by a public accountant.

9. Operation

A visiting nurse service at all times shall operate in accordance with these standards and such other requirements as are now or may hereafter be established by this Board.

Information and Assistance Are Available From Committee on Care for Christian Scientists, 107 Falmouth Street, Boston, Mass.

Senator ANDERSON. Thank you, Dr. Stokes, I appreciate the fact you made a short statement.

Dr. STOKES. Thank you.

Senator ANDERSON. Dr. Salmon?

STATEMENT OF DR. PIERRE SALMON, APPEARING ON BEHALF OF THE NATIONAL COUNCIL FOR THE ACCREDITATION OF NURSING HOMES; ACCOMPANIED BY JOHN PICKENS, GENERAL COUNSEL, NATIONAL COUNCIL FOR THE ACCREDITATION OF NURSING HOMES

Dr. SALMON. Mr. Chairman and members of the committee, I am Dr. Pierre Salmon of San Mateo, Calif. I am appearing on behalf of the National Council for the Accreditation of Nursing Homes.

With me is Mr. John Pickens, the general counsel of the National Council for the Accreditation of Nursing Homes.

I am one of the members of the board of directors representing the medical profession.

For the last several years, I have been superintendent of Institutional Clinical Services for San Mateo, Calif., Department of Public Health and Welfare. As such, I am responsible for 640 patients in proprietary nursing homes in San Mateo County and a total of 800 to 900 patients in long-term care facilities including a rehabilitation center and TB sanatorium.

I am also engaged in private practice of medicine, specializing in cardiovascular diseases. Among other positions which I hold are chairman of the California Commission for the Accreditation of Nursing Homes; chairman of California Commission on Health Care of Aging; member, Bay Area Health Facilities Planning Association; vice president, Bay Area Welfare and Planning Federation; and chairman, San Mateo County Health Facilities Planning Committee.

I shall restrict my remarks this morning, sir, to section 1865 of H.R. 6675 and more especially the portion having to do with the accreditation of extended care facilities. We proposed that section 1865 be amended to specifically recognize the accreditation program of the National Council for the Accreditation of Nursing Homes. Our proposed amendments are attached to my prepared statement as appendix A.

We believe that where a national accreditation program has been undertaken by an independent bilateral body having the stature of the National Council for the Accreditation of Nursing Homes, it should be recognized in the bill.

The composition of the national council is very similar to the Joint Commission on the Accreditation of Hospitals which section 1865 specifically recognizes in regard to hospital accreditation. The national council is composed of outstanding physicians and nursing home administrators among whom are a former hospital administrator, a well known medical social worker and a well known registered nurse with many years of experience in the public health nurse field.

The chairman of the national council, Dr. H. Close Hesseltine, is also a member of the Joint Commission on the Accreditation of Hospitals. For your information, a short biography of each member of the board of directors is attached to my prepared statement as appendix B.

The American Nursing Home Association (ANHA) worked for a decade toward the establishment of a national accreditation program for nursing homes. It carried on this program when others lost or lacked interest. In the spring of 1963, the American Medical Association came to the financial aid of ANHA and jointly sponsored the formation of the National Council for the Accreditation of Nursing Homes, whose principal offices are located at 645 North Michigan Avenue, Chicago.

The AMA provided a similar service to the Joint Commission on Accreditation of Hospitals when, in 1952, the American College of Surgeons, which had conducted an accreditation program of hospitals,

found the continuing financial burden too great and suggested that other organizations should aid in the task of accrediting hospitals. At that time, AMA with the aid of AHA, saved the accreditation program of the Joint Commission on 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 those of the joint commission in the hospital field.

Today, the national council employs qualified and experienced nursing home surveyors throughout the country, and classifies nursing homes under three categories: Intensive nursing care, skilled nursing care and intermediate care.

The first two categories provide more rigid requirements than in H.R. 6675. It is believed these two classifications should be accepted under the medicare program. A 48-page booklet setting forth the "Standards for Accreditation" is attached to my prepared statement as appendix D. (In committee files.)

As the experience of the joint commission has demonstrated, voluntary policing in the medical and paramedical fields is the best and most efficient way to raise professional standards.

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.

On the other hand the board of the joint commission does not review each individual recommendation of its surveyors and staff.

Since H.R. 6675 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.

During the first year, the national council proceeded slowly and with thoroughness. To date, it has accredited 595 facilities in 43 States with a total of 39,530 beds.

At the present time, however, we are processing on the average of 12 new nursing home applications each week. At this rate, we will have surveyed approximately 900 more nursing homes within the next 18 months, or by the proposed effective date of the nursing home provisions of the medicare bill.

The national council's accreditation program is recognized by many Blue Cross plans, insurance programs and by the Veterans' Administration. In one or two instances it has been written into, and promulgated as, State regulations governing the nursing homes in which the States have placed their public assistance patients.

UTILIZATION REVIEW

The national council has rereviewed its standards of accreditation twice in the past 2 years. Its sole aim is to raise the standards of professional care in nursing homes as rapidly as possible. It is always looking for ways to improve its program. For this reason it does not ask that a provision be inserted in H.R. 6675 to the effect that the Secretary cannot promulgate standards higher than the national council requires, even though we do not believe this will happen because of the national council's dedication to progress and improvement.

Along this line, the national council, and its sponsoring organizations, has had under consideration for some time the accreditation of other extended care facilities other than nursing homes as well as a plan which includes utilization review.

At the present time, no other accrediting commission, council, listing or approval body has provision for utilization review as contemplated by section 1861(e)(6). It does not appear feasible for each extended care facility to establish its own utilization review mechanism.

However, the national council, through the cooperation of one of its sustaining members—the American Medical Association)—now is on the threshold of incorporating such a mechanism in its accreditation program.

The proposal embodies the creation of a "medical staff equivalent" by the local county medical society for the "aggregate of extended care facilities" within the local community. In this activity there would be close cooperation between the members of the local medical community and the administrators of extended care facilities. Within the committee structure would be contained the equivalent of the hospital executive committee, the medical audit committee, the procedural review committee and the utilization review committee.

The concept is detailed more explicitly in the draft of the document labeled "Physician-Long Term Care Facility Relationships," dated February 11, 1965, attached to my statement as appendix C, distributed to members of your committee.

The ultimate judges of appropriate utilization of extended care facilities must be physicians in each instance. The proposed concept requires that this judgment be made by a committee of physicians not directly involved with the treatment of the patients in question. Consequently, the committee would be as free as possible of influence from whatever quarter in arriving at its decisions from patient to patient. It would be more at liberty to express its opinions without trepidation. The National Council for the Accreditation of Nursing Homes, supported as it is by the American Medical Association, appears to be the only accrediting body for extended care facilities having the potential to incorporate a means of utilization review within its framework at this time.

It is recommended, therefore, that section 1865 of H.R. 6675 be amended 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 Accreditation of Hospitals, and (b) of section 1861(j) (except paragraph (6) 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).

Thank you very much, Mr. Chairman, and I will be happy to respond to questions.

Senator ANDERSON. Are those papers which you sent along rather long? I think it best we receive appendix D for the files of the committee and not place it in the record.

Is that agreeable with you?

Dr. SALMON. Yes, sir.

Senator LONG. Let me see if I understand this. You are saying that a nursing home would be eligible to participate in the program if it were either approved by the Secretary, as I understand it or by the council that you have here.

Is that the case or would you provide that they had to be approved by both?

Dr. SALMON. A long-term extended care facility, sir, would be approved by the national council. An acute hospital would be approved by the Joint Commission on Accreditation of Hospitals.

Senator LONG. Well now, as I understand it, you don't insist on the right of one of these extended care facilities to participate if the Secretary approves it, and your council does not, I take it.

In other words, as I understand it, the Secretary would have the right to pass judgment on the extended care facility and impose standards higher than your council?

Dr. SALMON. Yes; this I understand is the basic provisions of the bill. The Secretary may set up whatever standards he wishes. But as I stated in the statement, it is unlikely that the national council standards would be lower than those put forth by the Secretary.

Senator LONG. Well now, would you seek an amendment that would say if they meet the Secretary's standards but fail to meet the standards of the national council that they could not participate in the program?

Dr. SALMON. This statement suggests, sir, that just as the Joint Commission on Accreditation of Hopsitals was named as a specific mechanism for identification of acute hospitals, in which medicare patients would be treated, so accreditation by the national council would be recognized as a mechanism for long, extended care facilities where a patient could be treated.

There are other mechanisms, I understand, that are incoporated in the bill.

Senator LONG. What I have in mind is, assuming that we go along with you and recognize your group, so long as these facilities meet what is required by the Secretary of Health, Education, and Welfare, do I understand you would not insist that they should not participate in the program? Suppose your standards are higher but if a particular home meets the standards of the Secretary of HEW then you are not asking that it be barred from participating in the program?

Dr. SALMON. I do not believe that this is the intent, sir, nor do I believe it is the intent for hospitals, either, if I read the thing correctly. Mr. Pickens may be able to amplify this for you further.

Mr. PICKENS. No, Senator; you are correct. If an extended care facility, for example, has not been surveyed and approved by the national council, as long as it still meets the provisions of 1861(e) and whatever additional regulations the Secretary issued it would still be eligible under the bill. You are correct.

This is an alternative.

Senator LONG. So, in other words, what you are contending is that the Secretary could look at, look to the approval of the National Coun-

cil for the Accreditation of Nursing Homes, if he wanted to accept that as satisfactory indication that these nursing homes are all right but he wouldn't be required to do so.

Mr. PICKENS. That is correct. He could accept the bare provisions of the bill, for example, in accepting a nursing home as a provider of services or he could require additional regulations or he could accept the program of the national council. He really would have three alternatives.

Senator LONG. Thank you.

Senator ANDERSON. Doctor, do I read this correctly, that you have now accredited 595 institutions in 43 States?

Dr. SALMON. Yes.

Senator ANDERSON. Have they been accredited as intensive care facilities or skilled nursing homes?

Dr. SALMON. They have accredited all classes, sir. I don't have the breakdown at the moment. I can provide it for you.

(The breakdown was not furnished as promised.)

Senator ANDERSON. Have your standards been published and made available to the public?

Dr. SALMON. Yes, sir; they have and a copy of them are attached hereto.

(In committee files.)

Senator ANDERSON. Has your program developed to a point where it uses objective criteria, say, for instance of fire safety, which experience shows has been respected uniformly throughout the country?

Dr. SALMON. Yes, sir; there are regulations having to do with the safety of the patient.

Senator ANDERSON. Those are included in the standards which you have supplied to us?

Dr. SALMON. Yes, sir.

Senator ANDERSON. Is it true these proprietary homes sort of gravitate toward your program and nonprofit homes toward the American Hospital Association program?

Dr. SALMON. This is an opinion which I think I am not qualified to answer nor do I believe anyone is.

Senator ANDERSON. Well, you say it is an opinion. I am merely asking isn't it true that most of the proprietary places want your program and the nonprofit ones want the Hospital Association program?

Mr. PICKENS. Senator, if I may answer that, I don't think that is the case.

The American Nursing Home Association, which, along with the American Medical Association which sponsors this national council, represents both proprietary and nonproprietary homes.

As a matter of fact, I believe they have more nonprofit homes than AAHA has. About 15 percent of the American Nursing Home Association are nonprofit. Their total membership is over 5,000. In answer to your question on the number of beds accredited there are, I think, 39,500 beds.

Senator ANDERSON. Your statement says 39,500, yes.

Mr. PICKENS. 5,000 of those beds are intermediate care homes, and we are not asking that our intermediate care category be recognized.

So, of the homes that would qualify under the bill as defined as an extended care facility to be eligible, at the present time you would have approximately 35,000-plus beds that have been accredited.

Senator ANDERSON. My question relates to this question of the nonprofit and the profit institutions. The profit institutions seem mainly directed toward your accreditation.

The nonprofit prefer the American Hospital Association, isn't that correct?

Mr. PICKENS. No, I don't believe that is correct. Senator, we can supply you with figures.

(The figures were not furnished as promised.)

Senator ANDERSON. You can? Thank you very much.

Mr. PICKENS. Senator, I wonder if appendixes A, B, and C could be entered into the record?—C, I think, is very important, because it is a new concept of utilization review.

Senator ANDERSON. They will be printed in the record.

Thank you very much.

Dr. SALMON. Thank you.

(The information referred to follows:)

APPENDIX A

SUGGESTED NCANH AMENDMENTS TO MEDICARE H.R. 6675 (HOUSE-PASSED BILL)

I. Amend section 1863 by striking out the words "listing or" on line 7 between the word "National" and the words "accrediting bodies."

Explanation: Mere listing bodies should not be consulted in such serious matters as professional nursing home care. Listing is not a guarantee of quality or high standards as is accreditation. To leave "listing" in the bill will only serve to confuse the issue and make one believe something that is not true or valid.

II. 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) thereof) if such institution is accredited as a skilled or intensive care nursing home by the National Council for the Accreditation of Nursing Homes.*[1] 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 base 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: A national accreditation program that has been undertaken by an independent body such as the National Council for the Accreditation of Nursing Homes, and is not unilateral, 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.

[1] Italic indicates matter added to House-passed bill.

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 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.

APPENDIX B

BIOGRAPHY OF THE MEMBERS OF THE NATIONAL COUNCIL FOR THE ACCREDITATION OF NURSING HOMES

The National Council for the Accreditation of Nursing Homes has a rather distinguished board of directors, composed of five outstanding physicians and four outstanding nursing home leaders.

The chairman is Dr. H. Close Hesseltine, Chicago, a leading private practitioner and a professor of obstretrics and gynecology at the University of Chicago Medical School. He is a member of the joint commission on the accreditation of hospitals. He is past president of State of Illinois Medical Society. He has also served on various boards and committees of the Chicago Medical Society, the Illinois Medical Society, and the American Medical Association.

Its vice chairman is Mr. Alton Barlow, of Canton, N.Y., a former president of the American Nursing Home Association (1960–62); vice chairman of joint council to improve the health care of the aging (1960–62); chairman of tripartite liaison committee, AMA, AHA, and ANHA (1960); president, New York State Nursing Home Association (1953–61); member of White House Conference on Aging (1960); member of New York Governor's committee on aging (1959–61); fellow and member of the board of directors of American College of Nursing Home Administrators.

Mr. Barlow graduated from the Albany Business College in 1933. From 1933 to 1940 he was a nursing home administrator. From 1940 to 1949 he was administrator of the first general hospital in Canton, N.Y. From 1950 to date he has been owner and administrator of the Canton Nursing Home. At the present time, he has almost completed the construction of two new nursing homes, one at Ithaca, N.Y., and the other at Ogdensburgh, N.Y.

Its secretary, Mrs. Vesta Bowden, is a registered professional nurse and outstanding nursing home administrator. She was graduated from University of Denver with a B.S. degree in science, and from Columbia University with a master's in public health nursing. From 1948 to 1953, she was director of public health nursing for the Colorado State Department of Public Health. Prior to that time she had been in visiting nursing service in Public Health Department of the City of Montclair, N.J. She was first trained nurse in public health nursing and acted as the community public health nurse in Oklahoma City, Okla.

For the past 15 years she has been a nursing home owner and administrator in Aurora, Colo. Governor Johnson appointed her to the Colorado Commission on Aging (1957–59). She has been a regional vice president (1958), chairman of ethics committee (1960–) and a member of accreditation committee (1960–) of American Nursing Home Association.

She is a member of the board of directors and past president of the Colorado Nursing Home Association, Business & Professional Woman's Association of Denver and was chosen Woman of the Year in 1959.

Three of the other directors are Dr. Frederick C. Swartz, Lansing, Mich., a leading internist with wide experience in the field of diseases of the aged and aging, among others, and chairman of the American Medical Association's Committee on Aging. Dr. Swartz is an M.D. and FACP; is chief, department of internal medicine, St. Lawrence hospital; diplomat, American Board of Internal Medicine; chairman, American Medical Association Committee on Aging; member, American College of Physicians; past chairman, joint council to improve the health care of the aging, International and American Gerontological Societies, American Geriatric Society.

Mrs. Eleanor Baird, of New Milford, Conn., is a leading medical social worker with 17 years' experience in the field of accreditation. She was graduated from the College of Ste. Rose and the Fordham University School of Social Work. She has been director of personnel and employment for a large printing firm. She organized and was the first director of medical social services of St. Barnabas Hospital for Chronic Diseases and its affiliated Broker Home for Aged in Bronx, N.Y.

She was the prime mover in accreditation in the State of Connecticut. She has been chairman of ANHA accreditation committee since 1961. She has been chairman of the National Council for Accreditation of Nursing Homes (1963); member of Advisory Committee to White House Conference on Aging (1960); treasurer of the Connecticut Chronic and Convalescent Hospital Association. She is active in many organizations concerned with problems of chronic diseases and aging. For the past several years she has been administrator of the Twin Pines Convalescing Hospital of New Milford.

Dr. JOHN H. Kelley, of Des Moines, Iowa, is a specialist in orthopedics and physical medicine. He graduated from Northwestern Medical School, interned at Cook County Hospital in Chicago and served his residency at Mayo Clinic in Rochester, Minn. He is a diplomat, Board of Orthopaedic Surgery; member, Academy of Orthopaedic Surgeons, Clinical Orthopaedic Society; Mid-Central States Orthopedic Society, and American Medical Association.

He is a member of the board of directors of Iowa Arthritis and Rheumatism Society, Des Moines Convalescent Home, and Employers Mutual Cos. (of which he is also medical director).

Among other outstanding directors are Dr. Pierre Salmon, San Mateo, Calif., a leading public health officer and a member of the California Commission for the Accreditation of Nursing Homes and Related Facilities. He is superintendent of institutional clinical services for San Mateo County, Calif. As such, he is responsible for 640 patients in proprietary nursing homes in San Mateo County and a total of 800 to 900 patients in long-term-care facilities including a rehabilitation center and TB sanitarium. He is engaged in the private practice of medicine, specializing in cardiovascular diseases.

He is chairman, California on Health Care of the Aging; a member Bay Area Health Facilities Planning Association; vice president, Bay Area Welfare and Planning Federation; and chairman, San Mateo County Health Facilities Planning Committee. He is a well-known author and lecturer.

Dr. Wilson T. Sowder, Jacksonville, Fla., is a well-known physician and the commissioner of health for the State of Florida. He received his medical education at University of Virginia. He received his M.P.H. degree from Johns Hopkins. He received his postgraduate hospital training at University of Iowa Hospital, Iowa City; St. Luke's Hospital, San Francisco, and U.S. Public Health Service. During the course of his public health service, his various assignments included hospital work, quarantine service, and Coast Guard service in Alaska; consultant on communicable disease control with War Shipping Administration, and regional consultant to the Dallas Regional Office of Public Health Service.

From 1945 to 1961 and from 1963 to date he has been State health officer for the State of Florida. During the interim period he was chief, Office of Aging, Bureau of State Services, Public Health Service, in Washington.

Among other positions, he has been a member of U.S. delegation to 13th World Health Conference at Geneva; chairman, section of preventive medicine, American Medical Association; consultant AID program to Ecuador; president, Florida Public Health Association; president, American Association of Public Health Physicians; and president, State and Territorial Health Officers Association.

Mrs. Pauline Williams, of Phoenix, Ariz., is an outstanding nursing home administrator. She graduated in nursing from Mennonite Hospital in 1923. Thereafter she did private duty nursing. She then studied physiatry and social studies at University of Oklahoma and at Menninger Clinic at Topeka, Kans. She was president of Arizona Association of Nursing Homes for 4 years; member, ANHA accreditation committee for past several years. She is a member of board of directors of Business and Professional Women's Club of Phoenix and vice president of the Phoenix club.

APPENDIX C

PHYSICAN—LONG-TERM-CARE FACILITY RELATIONSHIPS

(A concept intended to assist component medical societies in developing a structure for close liaison between the medical community and facilities providing supportive care for chronically ill patients)

The guiding principles for physician-hospital relationships, adopted by the California Medical Association in1960, has been useful in acquainting physicans with the organizational patterns of hospital medical staffs and delineating the

responsibilities of physicians as hospital staff members. In an attempt to provide similar guidelines for physicians treating patients in long-term-care facilities, the California Medical Association has adopted this set of principles for use in the several types of institutions devoted to care of chronically ill and disabled patients.

The document provides a format—

(1) Which should increase the interest and active participation of community physicians in the affairs of long-term facilities;

(2) Through which administrators/operators of long-term care facilities may communicate effectively with physicians; and

(3) Which should result in improved quality of medical and nursing care in long-term facilities.

Because physicians are acquainted with the concept of medical staff committee structure and activities, this pamphlet is constructed in a format comparable to that of the physician-hospital relationship guiding principles.

The basic principle on which these guidelines for long-term-care facilities stands is the establishment of a "medical staff equivalent" by the component county medical society for the "aggregate community of long-term-care facilities."

By this is meant that the medical society in a county would join with representatives of long-term-care facilities to create the "medical staff equivalent" and its various committees as described below to achieve the objectives listed above. In larger communities it may be necessary for the county medical society to carry out this function on a district basis rather than as a single entity, either because of geographic considerations or population distributions. In smaller communities, some of the committee functions may be combined in conformance with local needs. The principles will be set forth on the assumption that the county planning to utilize the method is of such a size that each of the committees may function as described. Local adaptations of the concept may be extremely variable but the central theme of bringing together members of the medical society and members of the community of long-term-care facility administrators for the welfare of the patients and for mutual support should not be lost. Thus, there would be a single "medical staff equivalent" for all the facilities in a county or a district, not a separate "medical staff" for each facility. It should be kept in mind that physicians serving on the various committees of the "medical staff equivalent" will not be involved in direct patient care any more than they would be if serving on hospital medical staff committees.

DEFINITION OF LONG-TERM-CARE FACILITIES IN CALIFORNIA

There is confusion among physicians as well as in the public mind about the definitions of long-term-care facilities in general. Many attempts have been made to describe the variety of services available in the different categories, but labels tend to be used inexactly and inappropriately by the majority of physicians and practically all lay persons. In California, the State department of public health is responsible for licensing facilities providing long-term medical and/or nursing care. The facilities are licensed under the generic term "hospital," which includes such installations as sanatoriums, nursing homes, convalescent homes, convalescent hospitals, chronic disease hospitals, tuberculosis nursing homes, tuberculosis hospitals, and specialized hospitals. The characteristic which these facilities have in common is their structure designed to provide medical and/or nursing care for patients with long-term illnesses or disabilities, or for patients convelescing from an acute illness or disability. General hospitals are primarily structured to treat illnesses and disabilities of relatively short duration.

The State department of social welfare, on the other hand, is responsible for licensing so-called rest homes, either directly or by delegation of this responsibility to individual counties, depending on the size or capacity of the home. Rest homes are also known by a variety of other names, including homes for the well-aged, boarding homes, group care facilities, domiciliary care facilities, congregate living homes, retirement living homes and nonmedical out-of-home facilities. There may also be other synonyms. Residents in these facilities are provided with food and shelter, medical and/or nursing care being available only incidentally. The analogy to a person living in his own home may be made. If the resident of a boarding home can take his medications without assistance or with minimal assistance from the operator, he is appropriately situated. If he is not

self-sufficient to this degree, if he requires nursing care or supervision regularly, and is under the professional care of a physician for the illness or disability which makes him dependent on nursing care or supervision, by law, he may not be retained in a boarding home.

Similarly, the State department of mental hygiene is responsible for licensing long-term-care facilities looking after the mentally ill. These, too, are divided into categories roughly comparable to the installations under the jurisdiction of both the State department of public health and the State department of social welfare. The types with which comparison may be made are type G, facilities for mentally ill senile patients, and type R, residential care centers for mentally retarded or emotionally disturbed patients.

The distinctions are not precise. There are many areas of potential overlap and a person may have his needs for support change from time to time in a chronic situation. The vagueness of the categories may be diminshed in specific cases by consultation between the physician and the administrator of the prospective long-term facility about the needs of the patient or resident in question. If discussion takes place before placement, the responsible administrator will invariably state whether or not his facility is designed and operated to take proper care of the person seeking aid. Additionally, there is variation among the abilities of facilities licensed as nursing homes to handle different types of medical problems. Some homes can provide a highly sophisticated level of professional care, while others may merely be capable of giving a minimal sort of custodial care to patients of advanced age or with diseases of advanced and irreversible natures.

These guiding principles are designed to foster the interchange of information about facilities and their capabilities between physicians and administrators.

ACCREDITATION OF LONG-TERM-CARE FACILITIES

Accreditation of hospitals has been in existence for almost half a century and has been an important factor in improving the quality of medical care in many hospitals across the country. Accreditation of long-term-care facilities is a relatively new activity, not yet having the far-reaching effects obtained in hospitals. The principle, however, is similar. Essentially, the process consists of survey of a facility by the representative of a nongovernmental agency which has developed standards of performance considered to be compatible with a good quality of medical and/or nursing care. The surveyor uses the standards to assess the capability of a facility to provide such care. A certificate is generally issued attesting to the fact that, in the judgment of the accrediting body, the facility has the capability of performing in accordance with the standards and was doing so at the time of survey. The certificate is generally valid for a period of several years, as long as the facility remains under the same ownership or administration. Resurvey is carried out periodically.

Licensure by a Government agency is primarily concerned with standards of construction, safety, and certain areas of performance. The licensing agency usually carries on periodic inspections and has policing power to compel the facility to comply with official regulations. The accrediting body is a voluntary group and has no such power, having to rely on the authority of education and persuasion to attain its goals. However, the denial of accreditation after survey is frequently a potent force affecting the quality of operation in long-term facilities.

MAINTENANCE OF QUALITY CARE IN LONG-TERM-CARE FACILITIES

These guiding principles suggest a means by which good quality care can be reasonably assured in fostering improved communication between physicians and administrators of long-term-care facilities and creating a mechanism conducive to the solution of many problems shared by the two groups.

The guiding principles contain basic concepts designed to serve the public interest. They are not precise mechanisms for universal use but rather should serve as descriptions of goals to be achieved. The underlying philosophy appears to have sufficient validity to be applicable to any area throughout the country, from the smallest community where perhaps a single facility may exist, to large metropolitan centers with a great number of institutions. Application of the guiding principle assumes an expenditure of energy by the membership of the county medical society, but the total level of energy expenditure should be proportionately equal in a small community to the effort made in a large one,

for obvious reasons. The committee activities should be spread among as many physicians as is feasible in a given locale to avoid the pitfall of having a few individuals involved in the situation with the bulk of physicians abrogating their responsibilities in this increasingly important field.

The quality of general care which patients receive is affected by the cooperation, understanding, and coordination reflected in high morale and good rapport existing among the physicians, the administrative staff, the nursing staff, and the governing body of a facility.

ROLE OF THE GOVERNING BODY IN LONG-TERM-CARE FACILITIES

The governing authority of a long-term-care facility may be a governmental agency, an elected or appointed board of trustees, a board of directors, an individual proprietor, a corporate proprietor, or a partnership. Hereinafter it shall be referred to as the governing body. It is legally and morally responsible for the manner in which the facility is conducted, including the responsibility that each patient in the facility is being treated regularly by a physician legally licensed to practice medicine.

ROLE OF THE PHYSICIAN IN THE LONG-TERM-CARE FACILITY

The primary responsibility of a physician is to render medical care to the ill and disabled persons who have selected him as their physician or who have been placed in his care by a responsible agent. In discharging his responsibility he is expected to bring to bear all his medical skill and judgment. His responsibility in long-term situations differs in no way from those inherent in acute illnesses or disabilities.

ROLE OF COMMITTEES IN LONG-TERM-CARE FACILITIES

It is through the combined activities of the committees described below that continuing direct control of the quality of medical and/or nursing care may be maintained. Even though a community may see fit not to establish each of the committees as described, it is important that the functions enumerated for each committee be contained within the operational framework as it is finally constituted. The specific format of the relationship matrix between physicians and the others responsible for provision of long-term care to patients is immaterial so long as the basic mechanisms for interaction are preserved. These committees will influence the interaction of the governing body, the administrative staff, the nursing staff, and the physicians in specific facilities, the combination ultimately responsible for the level of performance. Each facility may choose the intensity of care which it deems itself capable of rendering, but, in each instance, it must be prepared to provide the best quality. The "medical staff equivalent" provides the means of insuring the maintenance of good-quality performance at whatever level of intensity by means of joint interaction between physicians and representatives of long-term-care facilities.

1. *Executive committee.*—This committee should consist of a combination of physicians and representatives of long-term-care facilities. The total number of members should be in keeping with the size of the community in which it functions. The ratio between physicians and institutional representatives should be approximately 2 to 1. The physician members should be the chairmen of the other committees described below, plus enough others to constitute a number which may function efficiently and realistically. Its duties would be to coordinate the general policies and specific activities of the facilities within its jurisdiction. Acting in concert with a representative from the governing body of each facility, it should identify the intensity of nursing care available in the separate institutions based on—

(*a*) The expressed desire of the individual governing body about the intensity of care which it intends to provide; e.g., basic, intermediate, intensive;

(*b*) The preparations which the governing body has made to deliver the proposed level of care as expressed in staffing patterns, availability of personnel with appropriate abilities, availability of equipment for use by nursing personnel and physicians plus the physical construction of the facility itself; and

(*c*) Regular assessments of the manner in which the facility as an entity is carrying out its functions.

The executive committee should be responsible for publicizing its findings through the periodical or bulletin which most county medical societies publish regularly for physicians, and should maintain a listing of homes and their qualifications at the society headquarters for use in advising the public. Because these listings would result from the concerted action of physicians and administrators/owners judging their peers, it can be expected that adequate checks and balances will operate to make the process feasible in any community where professional integrity is intact and the motivation of all concerned is directed mainly toward adequate patient care.

The executive committee should be paramount among the suggested committees, should set policy, anticipate future needs, and act as the planning body. It should be the final determinant in all decisions recommended by the other committees and should be responsible ultimately for disciplinary actions involving both physicians and long-term-care facilities. It should be employed to act appropriately on the basis of its deliberations. Its power to act should be manifested mainly through educational means and the authority of informed persuasion whenever possible, but it should recommend disciplinary sanctions to the appropriate body when the occasion demands.

2. The medical audit committee should consist of physicians only, sufficient in number to serve the community in which it operates. The chairman should be a member of the executive committee. The committee would review medical records in the long-term-care facilities and would attempt to see that a reasonable reconstruction of the patient's illness could be made from the information put down on paper, not only by the physician but by other personnel in contact with the patient. It would not be thought necessary, for instance, to have a "medical student" type history and physical examination recorded in the long-term-facility chart, but a description of the patient's illness and physical findings, adequate to permit a new physician taking over the case to understand the situation and what has gone on, would be considered minimal. An assessment of the patient's prognosis and his potential to profit from restorative techniques should also be included. A specific plan of treatment should be outlined, preferably in conference with the long-term-care facility staff, and recorded in brief fashion. Specific orders for medications and treatment procedures should be written and should show evidence of periodic review. Automatic "stop orders" at reasonable intervals should be considered. Progress notes should be made at each visit. Evidence of regular visits by the physicians should be recorded, generally at intervals of not less than 30 days, and more often if the clinical state warrants it. Efforts should be made to have this committee function by educational means, through persuasion and precept. Failing success through this means, the matter should be referred to the executive committee.

The medical audit committee should also be interested in the way individuals other than the physician in contact with the patient record their observations and actions. It might be concerned with developing or adopting a standard set of forms to be used in the long-term-care facilities of the community. The quality of brevity should be sought in the standardized forms without sacrificing the essential function of a medical record, accurate reflection of a patient's condition during the various phases of his illness or disability.

3. The procedural review committee should consist of an equal number of physicians and representatives from long-term-care facilities. The chairman should preferably be a physician and a member of the executive committee. The scope of this group's responsibility should be to review the whole situation as seen by someone interested in the patient as an entity, a human being entitled to the best efforts of the treatment group to which his case has been given. In order to take advantage of all the resources available in the community, both in being or as potential aids, this committee should establish and maintain continuing contact with knowledgeable persons working in a variety of fields. The contact could be preserved through the use of such persons as consultants to the committee, through the use of subcommittees, or by whatever means will best serve in a given instance. Examples of persons useful in this way would be social workers, nurses, therapists, clergymen, lay individuals with specific fields of knowledge and interest, members of the community council, service clubs, chambers of commerce, and others with unique attributes beneficial in long-term situations. The committee's responsibility should entail the exercise of judgment for the most part and it should attempt to establish a norm of performance for the medical community and the community of long-term-care facilities as a point of reference. Again, its function would have to be largely educational and

persuasive rather than authoritarian, with disciplinary measures brought to bear, as suggested above, through the executive committee.

4. The utilization committee should consist solely of physicians, with the number in keeping with the size of the community in which it functions. The chairman should be a member of the executive committee. It might be productive to have the medical consultant to the county welfare department as a member of the committee, or as a consultant meeting regularly with the committee.

The utilization committee should have a most important function in these times when payment for long-term care is so often being made by third parties, both governmental and nongovernmental. Insurance companies have been hesitant about developing and selling policies for this type of medical care because of the absence of "controls." They are fearful that individuals who need less expensive domiciliary care will be housed in nursing facilities inappropriately because of the existence of an insurance policy covering the care of chronic illness. If the utilization committee could give assurance regularly that the nursing facilities' beds are being used for the treatment of long-term illness legitimately, it would go a long way toward fostering the entry of more underwriters into the business of paying for nursing home care on a realistic basis. The utilization committee could also familiarize itself with other resources available in the community and be prepared to make constructive suggestions about the use of boarding homes, foster homes, home care programs, housekeeping services, visiting nurse services, etc., when a decision is reached that a specific patient is occupying a nursing-type bed inappropriately. As stated previously, constant liaison with appropriate community agencies should be maintained in order to be continuously aware of the changing resources existent within the community.

The utilization committee should also concern itself with the level of practice by the physicians treating patients in long-term care facilities in such matters as the appropriate use of diagnostic laboratory procedures, judicious prescription of drugs and medications, restorative techniques, and regular assessment of the entire therapeutic regimen.

Actions of Committees

The initiative in the formation of the committees should be taken by the county medical society. The responsible officers of the component medical society should seek out their counterparts in the local chapters of the association of long-term care facilities, if such a chapter exists. The feasibility of organizing the committee system should be discussed and local adaptations of the basic concept should be made by mutual agreement. The relationships between the medical society and the long-term care association should be on a peer basis, with neither group assuming a superior role or an inferior role during the development stages or at any time throughout the continuing functional period of the committees. If no local association of long-term care facilities exists in a community, the responsible officers of the component medical society should invite the representatives of the community's long-term care facilities to meet collectively to explore the possibilities of committee relationships.

The physician members of the committees should be chosen carefully. They should be respected members of the medical community. They should have the realization that responsibility for the care of patients in long-term care facilities certainly equals the responsibility for the care of patients with acute illnesses and disabilities, and in many respects exceeds it. Because long intervals of time are involved in chronic illness and disability, the need for communication, planning and joint effort is intensified in the interest of effectiveness, economy, and efficiency.

The committees should meet regularly for discussion of the findings resulting from visits to the facilities of the community and for periodic assessment of their effectiveness. As experience is gained and mutual confidence is established, modifications of the original methodology may be brought about in the light of locally demonstrated needs. Visits to individual facilities should be made on a recurring schedule, sufficiently often so that the committees have reasonable assurance that their efforts are productive for the patients, for the physicians concerned and for the community of long-term care facilities. The committees should be ready to act on call of the chairman of any committee or when the executive committee considers it necessary. A system of reporting the findings and recommendations of the committees should be developed, incorporating methods for review of recommendations and appeal from decisions of the executive committee.

The officers and the constituency of the component medical society should recognize the necessity of planning for the increasing number of patients needing long-term care and the expanding expenditure of energy made in their behalf, expressed in terms of money, manpower, and material. Each of these can be considered without jeopardizing the proper care of the chronically ill patient when cooperative efforts are made with mutual trust in the integrity of all individuals concerned with the care of a patient over a prolonged period. In fact, the quality of care would undoubtedly be improved in such instances, all other things being equal.

Senator ANDERSON. The next is Dr. Gibson.

STATEMENT OF DR. ROBERT W. GIBSON, MEDICAL DIRECTOR, THE SHEPPARD AND ENOCH PRATT HOSPITAL, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. GIBSON. Mr. Chairman, and members of the committee, I am Dr. Robert Gibson, the medical director of the Sheppard and Enoch Pratt Hospital of Baltimore, Md.

I have been designated to represent the American Psychiatric Association. I am honored to have this opportunity to speak to you on behalf of the American Psychiatric Association whose 15,000 members have the primary responsibility for the medical treatment of the mentally ill in our country.

I should first like to express the gratitude of our profession for the significant progress that has been made in eliminating some of the provisions of the original medicare bill that discriminated against the elderly mentally ill and to which we had objected in strong terms last February.

While the basic hospital insurance program remains unchanged in this regard, the supplementary health benefits plan now incorporated into the bill does offer substantial coverage for mental health care albeit special conditions and limitations attached to it seem to us undesirable and unnecessary as I shall presently explain. We must also express our great pleasure that the bill eliminates longstanding discrimination against the mentally ill elderly patients in State hospitals with regard to the old-age assistance program; and we note that the increased funds that would be made available to the States for this part of the program must be used for improving the treatment and care of these patients rather than simply to help pay for existing and ongoing programs. We are in full accord with this wise provision.

It is also most gratifying that the bill provides for the extension of mental retardation planning and for substantially expanding maternal, child health, and crippled children's services. All of this is most desperately needed and will serve our Nation in good stead.

So, gentlemen, when I speak of our disappointment with some provisions in the bill regarding the mentally ill and our hope that these provisions can still be modified, I should like to make it clear that the American Psychiatric Association is not unappreciative of the progress that has been made in providing benefits for the mentally ill in this legislation; and further, I speak in the context of overall approval of a sound hospital insurance and health benefits program for our elderly citizens along the lines delineated in this bill.

It is abundantly clear that the American people wish to have their Federal Government share with their States, communities, voluntary agencies, and

individuals in insuring that elderly people who cannot afford it shall be guaranteed good hospital and medical care. The need has been amply demonstrated. The demand is just. The American Psychiatric Association supports it.

In that same public statement, however, we said that whatever mechanisms may be devised to implement the national will in this regard must make the same provision for the mental illnesses as for any other illnesses. Nothing less will do if we really mean it when we speak of a wholly new national approach to the greatest of all the Nation's health problems.

You will recall that, in the original version of the bill, the only treatment for mental illness provided for was that which could be carried out in a general hospital. We pointed out that this limitation was quite unjustified and made no sense for several reasons. Only about 20 percent of our general hospitals actually do offer psychiatric care, and, of the 60 urban areas in our country having a population of between 50,000 and 100,000 people, less than half of them have a general hospital with a psychiatric unit.

There are certain States—Arizona, for example—that have no psychiatric units in general hospitals. Thus the elderly citizen of such a State who develops a mental illness will be totally deprived of any benefits of the basic program.

Obviously, to limit care to these facilities is to eliminate treatment for thousands upon thousands of the elderly mentally ill. In short, it is discriminatory. But more than that, the general hospital psychiatric unit is very often not the appropriate place to treat these people. Sometimes the length of stay is limited to a matter of days rather than a few weeks. Often the service they render is primarily diagnostic. And, of course, other types of facilities can often render more appropriate treatment at far lower cost—private psychiatric hospitals, day hospitals, outpatient departments, community mental health centers, and so on.

The inclusion of the supplementary plan in the present version of the bill has to a limited extent blunted our initial disappointment; but in no way does it prompt us to withdraw our essential objections. At the very least we would hope that the Congress this year will include the accredited private psychiatric hospitals in the basic plan; but more than that we would very much like to see the basic plan redrafted so that it allowed for coverage of service in the complete range of psychiatric facilities. This would enable us to restore greater numbers of these elderly people to their families and communities than will be possible under the terms of the present limited basic plan.

The principle is a simple one: If our common objective is to restore the maximum number of the elderly citizens to useful lives through intensive psychiatric treatment, then we should make it possible to use all available instrumentalities of modern psychiatry.

It is a truism that patterns of medical care in our country will be drastically influenced by this legislation. If only general hospital care were to be provided in the basic plan, then we would surely expect those who are covered to seek that kind of care. No doubt the effect would be to engender a great deal of social pressure to expand general hospital psychiatry.

Nor is there objection to that per se.

But manifestly, general hospital care is geared to very short-term intensive treatment, running often to a few days and never more than a few weeks; and by its very nature it is a bed-centered program. Furthermore, it is expensive.

Ever so many of these elderly patients can more effectively be dealt with in a private psychiatric hospital, in a public mental hospital geriatric unit, in an outpatient facility, a part-time day hospital, through a home visiting service, and the like.

Often, the last thing they need is a "bed" in a general hospital and in many cases there is very little point in taxing such a facility. In short, the basic plan remains discriminatory and simply does not provide for flexibility in treatment methods. It is out of tune with the wholly new approach implicit in the new community psychiatry which the Congress has so vigorously supported. It is fundamentally incongruous with the overall intent of the bill to advance the health and well-being of our elderly citizens.

As for the voluntary supplementary plan, here again we are puzzled as to why the mentally ill should be singled out for special limitations in their benefits.

For example, we find the provisions for outpatient treatment will mean that the mentally ill patient is limited to $250. In any one year or 50 percent of the expense, whichever is smaller.

In the case of other illnesses there is no dollar limit on outpatient treatment and 80 percent of the expenses will be paid.

In the case of inpatient care, we find that the physician must "recertify" not later than the 20th day of hospitalization that the treatment can be reasonably expected to improve the condition of the patient. In the case of inpatient treatment of the mentally ill 80 percent of reasonable cost after a $50 deductible will be paid. In the case of other illnesses, all reasonable costs for semiprivate care after a $40 deductible will be paid.

The amount of inpatient care provided for the mentally ill person is 180 days in his lifetime. Why all this hedging about the mentally ill? Why not specify that the chronic cardiac patient shall receive only 180 days of care in his lifetime? Are not all of these special limitations and conditions really another reflection of our lack of faith in a "wholly new approach"? A feeling lurking in the back of our minds that these elderly people are not really treatable? That maybe their trouble is just advanced senility and somehow they are more expendable than the rest?

Gentlemen, I submit that it is morally wrong and completely unjustified to adopt this attitude of therapeutic pessimism about the elderly mentally ill. I, myself, recently conducted a survey of all the private hospitals which are members of the National Association of Private Psychiatric Hospitals. I found that they admit about 80,000 patients a year, 10 percent of them over 65 years of age. Of that 10 percent who were treated, 78 percent were back in their own homes in 2 months or less. I might add also that depressions are the most common of the mental illnesses among these elderly people and this is the most readily treatable of all the mental illnesses of psychotic severity.

No doubt much of the discriminatory conditions set forth in this legislation concerning mental illness derive from a concern that if the

mentally ill are treated exactly like all the rest, that it will "break the treasury." We do not think that any such assumption is justified.

And certainly, since the actuarial data is not presently available to support such alarm, any possible doubt ought to be resolved in favor of the elderly citizen who incurs a mental illness.

In conclusion, let me repeat that the American Psychiatric Association applauds this legislation as a giant step forward in meeting the health needs of the American people. But, at the same time, we cannot rest until our mentally ill citizens are accorded the same identical benefits provided for the citizens who suffer from other illnesses. We hope that the Congress will this year provide for greater flexibility in treating mental illness in the basic plan, and most especially by allowing for treatment in accredited private psychiatric hospitals as well as general hospitals.

We further hope that you will reconsider the discriminatory provisions attached to the mental illness in the voluntary supplementary plan. We ask for no special privileges but we do ask for an insurance and benefits system that will enable the profession of psychiatry to provide the right kind of treatment, at the right time, and at the right place for elderly mentally ill citizens.

Our association pledges its wholehearted support and cooperation to the Congress and to the public and private agencies and instrumentalities in making such an equitable system fully workable and maximally effective. The time has come, we submit, to root out all discrimination against the mentally ill, lock, stock, and barrel.

This is the principle on which we stand, and we hope we have your sympathetic ear.

Thank you.

Senator ANDERSON. Senator Long?

Senator LONG. Doctor, you have my sympathy. I agree with you that largely we have not done more for the mentally ill because the argument has been made that when we get into this field it is going to cost a lot of money. But this bill is going to cost a lot of money, and I personally see no logic to simply sweeping this problem under the rug and trying to pretend it doesn't exist when in many cases these are catastrophic cases, and there is just a lot of health care that is proposed under this bill for people who need it a lot less than some of these mentally ill cases.

You say a lot of these cases can be, at least, restored adequately so they can be sent back to their homes if they are treated?

Dr. GIBSON. Yes, sir. Yes; that is correct.

Senator LONG. And they could live a reasonably happy and to some extent a useful life if they can receive the treatment that they should have?

Dr. GIBSON. Yes, sir. I think a surprisingly high percentage. In round figures, it is about 80 percent, we have found in our treatment experience, and I think that this would compare very favorably with many of the other conditions that will be covered under the bill, cardiac conditions, the whole gamut of physical conditions.

Senator LONG. You think 80 percent of these aged people over 65 could be restored adequately to their homes?

Dr. GIBSON. We have found, if one takes the admissions, 80 percent of the admissions in the private psychiatric hospital were able to return to their homes within a period of 2 months.

I think what then happens, though, is of those who are not able to return, they frequently become long-term custodial patients who perhaps may live out their lives in a psychiatric hospital, and this group tends to gradually build up in size, so that one sees this specter of mental illness in the elderly as a large chronic problem of senility. But I think it has been skewed by that gradual increase in the ones that are not able to return; but of course, we are not suggesting that this type of custodial care in any way be covered under this program because the intent is for active treatment.

We are only interested in coverage where active treatment can reasonably be expected to return the person to a useful life.

Senator LONG. One of the unfortunate things that I have observed up to now is the provision in our Federal law that said that the Federal Government would match in a very generous fashion in providing old-age assistance under State welfare programs to people who are not in mental hospitals.

Now, take the case of someone who had been entitled to receive Federal assistance. Maybe the State would put up $20 and the Federal Government would match that with $40 to make it $60 but who then had to be put in one of those homes. The Federal Government would then cut off its share of the aid to the poor old person.

Dr. GIBSON. Yes, sir.

Senator LONG. That being so, the State can find it can make more effective use of its money by continuing to use its funds in the welfare program and by simply dropping the poor old person when he is locked up in a mental institution. The result is, with no Federal aid being available, that the care is pitiful, just absolutely pitiful, and that is even with the custodial part of it. It would seem to me that the least we could do is to take out of the law the prohibition against matching for aged citizens inside a mental institution.

We did the same thing to get rid of the old county poorhouse. We wanted to put that county poorhouse out of business. We didn't want to put these old people through the horrible conditions that existed in some of the county poorhouses where these poor wretches were taken and where they were worked until they were dead—killed, in effect.

So, while we sought to outlaw, to legislate, against that kind of horrible condition, we neglected to do the same with regard to mental institutions.

Now, of course, I don't think it was necessarily a calculated intent, but the effect was to put people in mental institutions to separate them from society until they died.

Dr. GIBSON. Yes, sir.

Senator LONG. And that being the case, it seems to me that part of this program ought also to work it out so that at least there is continued the matching that would be available to that person if he weren't inside a mental hospital.

In some instances you might have to give the assistance to the hospital or appoint a curator or a caretaker for the person and give the money to them. But it seems to me there is one area where we could make another step toward helping these aged people, feebleminded, who are in such shape that they are not going to be able to be effectively cured.

Dr. GIBSON. Yes, sir.

Senator LONG. You made a fine statement.
Thank you very much, Doctor.
Senator ANDERSON. Senator Talmadge?
Senator TALMADGE. No questions.
Senator ANDERSON. Doctor, there has been some talk about the Douglas amendment around here.
I assume you are familiar with it?
Dr. GIBSON. No, sir; I am sorry I am not familiar with it under that designation.
Senator ANDERSON. The House removed certain physicians who are working in hospitals, pathologists, radiologists and others, and put them over in a separate category under part B.
Do your members feel that the hospital staff should be included as a hospital item rather than be paid as staff psychiatrists?
Dr. GIBSON. Our organization has not studied that sufficiently to take a formal position. I would say that by and large within psychiatric hospitals the services of the physician are generally looked upon as a part of the overall treatment. Ordinarily you have salaried persons entirely looking after the patient and it doesn't make any sense to separate that out as a separate fee.
So, I cannot speak for the organization. I would say myself that I think that the salaries of staff psychiatrists should be looked upon as part of the basic coverage for care.
Senator ANDERSON. A staff member can give you a copy of the Douglas amendment if you desire and if you have a change in your comments we will be glad to have them later.
Dr. GIBSON. Thank you, sir.
Senator ANDERSON. The limitations of coverage of the bill on psychiatric hospital lead to the thought that some patients in some psychiatric institutions do not receive active treatment but really are just being held in custody.
Is there any truth in that?
Dr. GIBSON. Yes, sir. I think that for many patients that is appropriate—that is, if you have a case of advanced organic brain damage where there can be no recovery, then the only appropriate thing is a humane, comfortable custodial care for such a person. In some instances that will be appropriate.
Unfortunately, I think there is a tendency to lump all older people together so that this distinction is not made, and if they do come into an institution that is very large, is understaffed, which proper diagnosis and selection for treatment cannot be made, then many treatable older patients will be immediately looked upon as custodial, under those conditions they will become custodial and they won't be treatable any more.
So, we would certainly feel that the support should be to facilities that are providing active diagnostic and treatment services for these people, not simply a custodial care.
Senator ANDERSON. Thank you.
I thought you made a very interesting statement and we appreciate it.
Dr. GIBSON. Thank you, sir.
Senator ANDERSON. Thank you for your appearance.
Senator LONG. May I ask just one more thing?

Let me ask you this: Do we have enough psychiatrists and doctors who are trained in mental illness to do the job of caring for the people who need treatment?

Dr. GIBSON. No, sir. We don't have enough psychiatrists. We need more, and very active efforts are being made to train them. I think we also, as psychiatrists have to work to utilize the ones that we have most effectively. Part of the problem is one of uneven distribution of psychiatrists. They tend to be more concentrated around large metropolitan centers. This partly comes about because their training takes place in such places and they are apt to continue.

But we do not have a sufficient number. We need to consider this aspect of it very seriously to support training.

Senator LONG. Would you give me some estimate as to how many additional psychiatrists we need in this country, either percentagewise or any way that appeals to you to describe that situation?

Dr. GIBSON. I could only give the roughest approximation, but it has generally been accepted that we ought to have at least twice as many as we have now. There are some 15,000 members of the American Psychiatric Association and some additional psychiatrists who are not members, so this would mean on the order of 15,000 to 20,000 more I would say.

Senator LONG. If people had the ability to pay for psychiatric care for those cases that needed it, wouldn't you have an even greater shortage of psychiatrists to care for mental cases?

Dr. GIBSON. I expect that that would be the initial effect of it, but, of course, as there is a greater demand for services, then we would hope that this would increase the supply of psychiatrists, the supply of psychiatrists would be increased to meet that.

There is another factor and that is that I think there are very few psychiatrists who work in the area of treatment of the mentally elderly ill and I think support of legislation of this type might generate a greater interest in the active treatment of this group, and that this would move some psychiatrists into that field.

Senator LONG. Thank you.

Senator ANDERSON. Thank you very much.

Dr. GIBSON. Thank you.

Senator ANDERSON. Dr. Wergeland?

STATEMENT OF DR. FLOYD L. WERGELAND, EXECUTIVE MEDICAL DIRECTOR, HEADQUARTERS, LEISURE WORLD FOUNDATION, LAGUNA HILLS, CALIF.; ACCOMPANIED BY ROBERT CARITHERS, DIRECTOR OF HOSPITAL ADMINISTRATION

Dr. WERGELAND. Mr. Chairman, and committee members, I am Floyd L. Wergeland, M.D., major general, Medical Corps, U.S. Army, retired, formerly Executive Director of the Office for Dependents Medical Care for the uniformed services, and currently the executive medical director for the Leisure World Foundation with headquarters at Laguna Hills, Calif.

It is a bit homelike to be here in Washington and to again reappear before our representative Members of the Senate. This is also medicare legislation H.R. 6675 that has brought me here again, but not the

medicare program authorized by the Dependents Medical Care Act for the uniformed services and passed by the 84th Congress, which has been very sucessful to date. It has been a valuable program for the morale and welfare of the armed services personnel.

Senator ANDERSON. May I just stop you there? I fear there may be some questions by people who read the proceedings, as to what the Leisure World Foundation may be.

Dr. WERGELAND. I hope to bring that out for you.

My presentation will include a brief background description of the medical program for the Leisure World Foundation residents to include its current relationship to the new medicare legislation for elderly citizens who are 65 years of age and older.

Our medical program has been received enthusiastically by our residents of the three active Leisure World communities. Two more are under construction. By 1966, we will have 5 active communities—Seal Beach with 11,000 population now, and growing; Laguna Hills, Calif., with 3,500 and 30,000 planned and growing fast; Walnut Creek, Calif. (near Oakland) with 3,000 and 17,000 planned; Olney, Md., locally, with 16,000 planned; Princeton, N.J., with 50,000 planned; and Chicago, with 50,000—a total of 174,000.

Therefore we do desire to be helpful by presenting to you such recommended changes which we believe will enhance the workability of the medicare legislation at the implementation level. Thereby we hope to assure its intended success within our Leisure World cities where the average age within each has been well over 65 years.

At each of our Leisure World cities we have a medical center which is operated as a group cooperative clinic and hospital service. The medical staff is salaried on a full- or part-time basis. We do have a number of medical specialists consultants who are called as needed.

In each area, except in one where it is 70–30 percent, we provide medical care and treatment on an 80–20-percent coverage, the resident patients paying the 20-percent portion.

Each resident does pay a regular monthly charge which includes in addition, home visits by the nursing service and ambulance calls when needed, but on an 80–20-percent ratio. We have general practitioners and specialists to fill the common needs to treat citizens 52 years of age and up. In the majority, our residents prefer to use our Leisure World medical services, although they are free to go elsewhere with the same coverage.

Upon arrival at our medical center, we make every effort to have each resident complete carefully a medical questionnaire. Then we suggest they have a physical examination, accomplished as soon as practicable. Together, these two procedures are primarily for our residents' health security and safety in case of any future emergency. Furthermore, it gives an excellent baseline reference to enhance our research studies on this anticipated large group of matured people in various age brackets.

Mr. Ross Cortese, the founder and builder of Leisure Worlds, has personally and through his corporation—Rossmoor Corp., set up at the University of Southern California in Los Angeles, the Rossmoor-Cortese Institute for the Study of Retirement & Aging.

The institute is being funded to what is projected will be a $4 million research organization. Headed by a highly experienced research doc-

tor formerly with the U.S. Public Health Service, we are of the opinion that this coordinated research organization can also prove to be of increasing national value because they will study the socioeconomic experience, as well as the medical trends of this tested, yet active, adult community.

There is an emphatic effort by our entire staff to sponsor the prevention of disease and safety from injury and we feel this is important with the hopes of reducing the need measurably for hospitalization and consequently the costs to us and to the Government.

There are included special features of design for comfort, convenience, and safety in their homes. We urge residents to participate in regular physical exercise. We stress neighborly association and generous use of the many activities in their beautiful environment. Everything is there—physical exercise, recreation, spiritual, educational, and cultural events, group tours and commercial entertainment—adding up to a healthful leisure time. We have professional-size golf courses, 3-par golf courses, riding stables, swimming pools, shuffleboards, sewing rooms, lapidary rooms, carpenter shops, et cetera, which our residents enjoy and do use freely. We have applied all the health knowledge we can muster to slow down senescence; to close the gap between practical knowledge and an active health program. This we do by not only educating the residents to their health needs, but by using preventive measures and by having a high-quality health service conveniently available at a cost economically compatible with their resources.

We wish we would have had more influence in their daily living habits long before they arrived at our communities; but we get them busy on improving their personal health right away. In fact, some get so interested and busy, they do not visit their older homes nearby as frequently as they formerly thought would be necessary.

Dr. S. Paul Ehrlich, Jr., and colleagues (Donald B. Loveland, Reuel A. Stallones, and Weldon A. Williamson) of the U.S. Public Health Service published an article, "An Approach to the Study of Health in a Retirement Community," from studies at the Rossmoor-Leisure World community at Seal Beach, Calif.

Here are 11,000 elderly people over 52 years of age in 6,500 1- and 2-bedroom apartment manors on a 540-acre plot. It has a large clinic with a full-time group of 18 physicians, 30 registered nurses, and ancillary personnel.

It began in July 1962. They noted that—

one-third of the population is less than 65 years of age and 40 percent are over the age of 70. The mean age is 69 for men and 68 for women, who are 60 percent of the total population.

Therefore the medicare legislation will benefit a large majority of our folks. Dr. Ehrlich concludes by saying:

The several approaches described are chiefly designed to enhance our understanding of the interrelationship between stroke, coronary disease, and the pathologic entity atherosclerosis. An older population in a community setting like that described offers us an unusual opportunity to explore these relationships from several directions simultaneously and to identify population characteristics associated with the occurrence of disease or the maintenance of health.

In another report, he adds:

Our program at Leisure World has the advantage of gathering medical information which is not confined to cardiovascular disease. Our information will assist as a baseline for study of other chronic diseases.

Twenty different medical research projects are currently being conducted, planned, or discussed at Leisure World communities, and the majority of these are being sponsored by the U.S. Public Health Service. Truly, we have just scratched the surface, and we are convinced the Rossmoor-Cortese Research Institute will be able to help us to develop better preventive measures and procedures that can improve and retain good health in our population. The institute has a number of socioeconomic research studies in process, which can be correlated with the medical research.

So, with this background, you can understand that we feel keenly responsible to our residents about their health. Our medical program was, and remains, the primary motivation for these people to live in our communities, regardless of the community they select.

Therefore, on behalf of, and for the benefit of our Leisure World residents, we want to make every reasonable effort to gear the administration of our program to the provisions of the health care measure medicare as finally passed. There are several provisions in H.R. 6675 which, if changed, would improve the measure and greatly simplify its administration for all who participate in the program. They are:

(1) The exclusion of the costs of the hospital services of radiologists, pathologists, physiatrists and anesthesiologists from the basic plan represents a departure from customary hospital practice and will pose serious management relations and costly accounting problems to all hospitals.

It is our recommendation that where the hospital provides the services of those specialists and their assistants, the cost should be reimbursable to the hospital under the basic plan. This would coincide with the current practices of all hospitalization insurance plans, including those financed in part or in whole by the Federal Government.

(2) We recognize the importance of patient participation in the payment of costs incurred through the means of deductibles. Our concern is with the variations in amounts of the deductibles among the various programs, the overlapping of deductibles, for example, between hospital outpatient and diagnostic services and inpatient hospitalization, and the generally confusing task of accounting for the deductibles.

It is our recommendation that the deductibles be simplified either by a consolidation into one sum, or by providing a uniformity in amounts among the various plans or services.

(3) Under the voluntary supplementary plan covering payment for physicians' services, it is our concern that provision be made to reimburse physicians' services under group practice arrangements. In our Leisure World program and in most group practices, physicians do not bill the patient directly, but receive their income through salary or other methods of group participation.

It is our recommendation that where physicians perform medical service on a salary basis, the bill for those services from the group organization or clinic should be approved for reimbursement under the voluntary supplementary plan.

We thank you for the privilege of presenting our recommendations to you, and respectfully request permission to submit a supplementary statement in detail for the record which will support our recommendations. We certainly hope that the high objectives stimulating the medicare legislation will be successfully reached.

Are there any questions?

(The supplement to Dr. Wergeland's statement follows:)

SUPPLEMENT TO THE STATEMENT OF FLOYD L. WERGELAND, M.D., EXECUTIVE MEDICAL DIRECTOR, HEADQUARTERS, LEISURE WORLD FOUNDATION, LAGUNA HILLS, CALIF.

The following statement is presented in supplement to and in elaboration of the remarks presented orally to the Committee on Finance of the U.S. Senate by Floyd L. Wergeland, M.D., recommending amendments to H.R. 6675 as passed by the House of Representatives. In this supplement, the recommendations presented orally will be repeated and discussed at greater length.

RECOMMENDATION

Where the hospital provides the services of radiologists, pathologists, physiatrists, and anesthesiologists, the cost should be reimbursable to the hospital under the basic plan.

The efforts of organized medicine and specifically affected medical and surgical specialty organizations to separate the professional practice of radiology, pathology, physiatry, and anesthesiology from hospital services have been underway for many years, with particular emphasis and activity in this regard during the past 10 years. The complaint has been voiced that while physicians may be in charge of and responsible for certain services provided patients in hospitals, they are not in most instances contacted professionally by the patient nor is the traditional personal doctor-patient relationship established with the exception of anesthesiology the doctor and patient rarely come into close contact and seldom is a direct service performed by the specialist for the patient. However, he does plan, supervise, and approve the procedures used as a standard operating procedure.

The difficulties in separating these specialists, particularly radiologists and pathologists, from the coverage of the basic plan are primarily administrative. The patient has been accustomed to receiving one itemized statement for all services received while a patient in the hospital, including radiology and pathology. He has been accustomed to having his insurance program cover these costs as a part of the hospital bill. All current hospitalization insurance plans, including those financed in part or in whole by the Federal Government, follow this procedure. The exclusion of these services under H.R. 6675 represents a distinct departure from customary hospital and insurance practice. The patient would now receive a bill from the hospital for a difficult-to-determine portion of the cost of the specific examination, and then will receive a separate bill from the physician who, in most instances, the patient will never have seen. This can only lead to strained patient and community relations for the hospital.

The problem might best be illustrated in the clinical laboratory. The pathologist, a doctor of medicine, is in fact and in principle usually responsible for all of the laboratory examinations performed in the hospital.

In most instances, the laboratory examinations are performed by technologists who are under the supervision, albeit remote, of the pathologist. Seldom, with the exception of gross and microscopic examination of pathological tissue, does the pathologist become directly involved in performing or interpreting routine laboratory examinations. Yet, if the provisions of H.R. 6675 are to be followed to the letter, the patient will receive a bill from the pathologist for his professional service, and will in addition be billed separately by the hospital for the supplies, labor, time, etc., for the laboratory examination.

No one can argue with the desire of the specialists for professional recognition. This desire is understandable and truly just. The problem, as such, does not exist for the specialist in private practice. Our argument is that where these specialists, by their own desire and for the economic advantage to them which hospital practice usually affords, have chosen to practice their specialties in the hospital and as hospital services, the costs for these services should be covered in the basic plan. The economics of medical practice should not be confused with ethics and should not serve to complicate and perhaps reduce the effectiveness of an otherwise comprehensive program of health care for the aged.

RECOMMENDATION 2

The provision for deductibles should be simplified, either by consolidation into one sum or by providing a uniformity in amount of deductibles among the various plans or services.

Under the provisions of H.R. 6675, three separate types and amounts of deductibles are provided. There is a $40 deductible amount for each inpatient hospital service per spell of illness, a $20 deductible amount for each outpatient hospital diagnostic service within a 20-day period, and a $50 deductible under the voluntary supplementary plan for physicians' and other services on an annual basis.

Under the basic plan, the outpatient diagnostic service deductible of $20 can be applied against the inpatient hospital deductible of $40 if the patient is hospitalized within 20 days after receiving the outpatient diagnostic service. On the surface, this would appear quite simple. In practice, it will mean that an open file will have to be maintained on each hospital outpatient for at least 20 days following the service, just in case the patient is hospitalized within that period of time. Unless the hospital maintains such an active and open file, the burden of proof would rest with the patient. This in itself would present many problems and is not believed to be the intent of the legislation.

In spite of the variables in amounts of deductibles, it would seem that the deductible provision for the outpatient hospital diagnostic service might present the most problems. One suggestion for simplifying the procedure would be to eliminate the deductible for these outpatient services, substituting the application of the 80 percent-20 percent plan for them.

A difficulty will also be experienced in the fact that outpatient hospital diagnostic services are covered under both the basic plan and under the voluntary supplementary plan. The question will arise as to which plan takes precedence.

For example, a patient may have satisfied his deductible provision under the supplementary plan when, on order of his physician, he receives a diagnostic X-ray or other services in the hospital outpatient department. Difficulties will arise in determining whether the $20 deductible under the basic plan applies or whether his deductible provision under the supplementary plan has satisfied all requirements. Since no outpatient diagnostic service should be performed other than on order of a physician, excluding emergency services, it would seem that another solution might be to restrict outpatient diagnostic services to the voluntary supplementary plan.

In any event, we ask the committee to give consideration to simplifying the deductible provisions with a view to improving the administration of the program.

RECOMMENDATION 3

Where bills for physician services are submitted to the patient by the clinic or organization in a group practice arrangement, provision should be made for reimbursement to the clinic or group practice organization under the voluntary supplementary plan.

In the growing number of group practices in this Nation today, it is customary that the invoice or bill for physicians' services be submitted to the patient by the clinic or in the name of the group practice organization. Under these arrangements, physicians practice as members of the group, receiving their income through salary or through other methods of group or partnership participation. In these instances, the physician does not bill the patient directly.

The efficacy of group practice of medicine has been ably demonstrated in all sections of the Nation. The experience of the Leisure World medical program has paralleled other group practice experience and has demonstrated clearly an overall reduction in utilization of hospital services. Throughout this Nation today, the number of hospital admissions for all age groups in the population now approximates 134 per 1,000 persons. In the Leisure Worlds, with a population predominantly over the age of 65 years, the experience has shown so far an average of only 90 hospital admissions per 1,000 residents. This compares quite favorably with the experience of this age group in the Nation at large where average admissions are well over 150 per 1,000 and in some areas approach 200 per 1,000 per year. Furthermore, the average length of stay for Leisure World residents has been only 9 days, compared to 12 to 14 days on the national average for the older age groups.

The favorable experience of Leisure World residents with reference to hospitalization can be attributed in major part to the group practice medical program and the emphasis on prevention of illness or injury and maintenance of health within the community.

The objective is to keep people healthy and to maintain them in their residences rather than to hospitalize them, except where indicated by medical necessity. The real motivation is the recognition that only with good health can people fully enjoy "a new way of life" in Leisure World.

We feel that these cooperative group practice medical programs will greatly benefit the Federal program of health care for the aged by reducing overall utilization, by avoiding unnecessary utilization or abuse of the privileges, and by reducing the overall cost to the Federal Government. For these reasons, we believe that attention should be given to the provisions of the legislation to make certain that group practice programs are not in any way excluded from participation in the voluntary supplementary plan and that no problem develops as to the reimbursement of the group practice for physicians' services.

Senator ANDERSON. Senator Talmadge?

Senator TALMADGE. Doctor, I judge from what you say that this Leisure World is a combination of home with adequate medical services; is that approximately correct?

Dr. WERGELAND. That is true, sir.

Senator TALMADGE. How does one get to be a member or an occupant of Leisure World?

Dr. WERGELAND. To become a member of the Leisure World, you buy a manor and become a member by a down deposit on the manor which varies in whatever you choose as a pattern of the house in which you choose to live. After you have made your downpayment, then you have a monthly payment which includes your capital, the interest, the fire insurance, the cost of your medical program—the 80 percent of it—which is part of the overall charge. Our highest monthly charge runs approximately $120 per month. This includes all those things as the gardening service, the club facilities, the recreation facilities, and the transportation throughout the local community area.

Senator TALMADGE. In other words, for a average fee of approximately $180 a month——

Dr. WERGELAND. Yes, sir.

Senator TALMADGE. He has not only a home but adequate medical services also.

Dr. WERGELAND. That is right; 80 percent of them.

Senator TALMADGE. Is he required to pay any additional sum of money for any medical service he may have?

Dr. WERGELAND. He pays 20 percent of the cost, sir.

Senator TALMADGE. Also 20 percent of the medicine.

Dr. WERGELAND. Yes, sir; 20 percent of the medical care.

Senator TALMADGE. And Leisure Homes pays the other 80 percent?

Dr. WERGELAND. That is correct.

Senator TALMADGE. You referred to some foundation.

Is this made possible by some philanthropic effort on the part of these gentlemen's names you have mentioned?

Dr. WERGELAND. No, sir; this resource comes entirely from the people who purchase the manors.

Senator TALMADGE. Is this a profit organization?

Dr. WERGELAND. It is a nonprofit organization.

Senator TALMADGE. It is a nonprofit organization?

Dr. WERGELAND. That is right, sir.

Senator TALMADGE. In view of what you have said is there any real need for medicare for the occupants of your homes?

Dr. WERGELAND. Sir, because of the monthly income in the nonprofit organization, it has been estimated that this resource would take care of their medical costs and, of course, the medicare program for those over 65 will certainly require a downward adjustment in their monthly payments.

Senator TALMADGE. You take them in at any age I take it?
Dr. WERGELAND. Yes, sir; 52 and up.
Senator TALMADGE. Thank you.
No further questions.
Senator WILLIAMS. Doctor, how does this work?
Suppose one of these prospective members buys this property and pays you cash for the property. Are they sold for cash or is this just an installment operation?
Dr. WERGELAND. Senator, I am not on the sales force but I don't think it is permitted that he can buy this for cash.
Senator WILLIAMS. Then he must pay for his home on a monthly installment basis?
Dr. WERGELAND. Yes, sir; this is the way the service can be provided.
Senator WILLIAMS. When he gets his receipt for these monthly installments is that broken down so much for a payment of the property and so much for interest, and so forth?
Dr. WERGELAND. Correct.
Senator WILLIAMS. Yes.
Dr. WERGELAND. These payments can be itemized to the resident.
Senator WILLIAMS. Ultimately he will own that property outright?
Dr. WERGELAND. Yes, sir, he acquires an equity which can be transferred by inheritance to whomever he wishes to give it.
Senator WILLIAMS. After he has got this property paid for should he decide to sell it to anybody below the age of 52 can he sell it?
Dr. WERGELAND. No, sir; he has to be 52.
Senator WILLIAMS. Can he sell it to anybody he wishes who is 52 or over?
Dr. WERGELAND. Yes, sir.
Senator WILLIAMS. Is each purchaser automatically then in under your health program?
Dr. WERGELAND. Yes, sir. If they meet the requirements of the sale they become members of our community and the mutuals as we call them.
Senator WILLIAMS. On this itemized bill which the man receives, each man that lists a certain amount paid for health and other benefits, are these funds set aside, are they funded, or are they commingled with all of the funds of the foundation?
Dr. WERGELAND. I think our director of hospital administration can answer that best. This is Robert Carithers, who is director of hospital administration, Leisure World Foundation.
Mr. CARITHERS. Senator Williams, in answer to your question, actually it doesn't work exactly this way that an itemized statement is given each month. In effect, in this 1 monthly payment covering all the items which Dr. Wergeland has mentioned, the items, for example, care of physical properties, the maintenance of community facilities, the educational programs, the recreational programs, the medical programs, are all specifically identified in a monthly payment which is established at the beginning of each fiscal year.
Now, at the end of the fiscal year depending on how the operation has gone, the monthly payment can be adjusted slightly. We have been very fortunate that it has not had to be raised or lowered more than a fraction of a percentage point, but I think your question led to the point that at the end of 1 month, let's say, you wondered was the

resident billed for the services on an itemization and this determined his monthly payment.

That isn't the way it works.

Senator WILLIAMS. That wasn't my question at all. I was only repeating what the witness had said.

Mr. CARITHERS. I am sorry.

Senator WILLIAMS. He said that they paid $180 each month, for example, and that this was broken down so much representing the interest on the property purchases, so much for the principal of the property, so much for the recreational facilities, and so much for the medical attention.

I am asking you is that true or is it done differently. Are you telling me now that is——

Mr. CARITHERS. No; that is exactly right.

Senator WILLIAMS. We will go back to the point. Then you do know how much is being paid by these various members for medical attention, do you not?

Mr. CARITHERS. Oh, yes; I am sorry. I misunderstood you.

Senator WILLIAMS. My question is is that funded or is that commingled with all the other funds together.

Mr. CARITHERS. It is funded.

Senator WILLIAMS. It is a separate fund?

Mr. CARITHERS. Yes, sir.

Their monthly payment, that part specifically identified for the medical portion does set up a fund which covers, in effect, 80 percent of the cost of operating the medical program.

Senator WILLIAMS. I understand that it is separate as far as he pays for it. When you get the funds are they commingled with the other funds of the company or are these payments which you collect for insurance, for instance, set aside as a separate fund, earmarked specifically to be used for medical purposes, or are they commingled with all of your funds where they can be used toward a payment of the principal, salaries, and all the other expenses?

Mr. CARITHERS. No; it cannot be used for other purposes.

In other words, each operation has a budget, a line budget, and each one is audited at the end of the year and adjusted accordingly.

In other words, they could not use the medical portion of that monthly payment to pay for other services. At the end of the year, let's suppose that so much had been provided for the medical program, and only 90 percent of this amount had been used. In adjusting the budget for the following year that would be in the reserve of the medical program budget going into the next fiscal year, and it would not be used for other purposes.

Senator WILLIAMS. Then it would be commingled at the end of the year?

Mr. CARITHERS. No; it could then be used only to reduce the medical portion of their monthly payment in the following year.

Senator WILLIAMS. I see.

Mr. CARITHERS. It would not be commingled.

Senator WILLIAMS. Now, you refer to the Rossmoor-Cortese Institute. How is that financed? Is that separate from the foundation?

Mr. CARITHERS. It is separate from the Leisure World Foundation. This was established by Mr. Cortese with the University of Southern

California. Mr. Cortese is the principal owner of the Rossmoor Corp. which is the building corporation, I might point out.

As each manor unit is completed and sold he contributes a certain amount of money, which has been agreed upon with the University of Southern California, to the research institute.

Senator WILLIAMS. Does it have any other sources of income such as grants, Federal grants or otherwise?

Mr. CARITHERS. It does not at this time. But they certainly would anticipate making application for any worthwhile project which could be of benefit to a study of the aged.

Senator WILLIAMS. But as yet it has not?

Mr. CARITHERS. It has not.

Senator WILLIAMS. Is this project itself, the foundation and all of this construction project, being financed by private means or is it part of a federally financed project?

Mr. CARITHERS. This is by private means completely.

Senator WILLIAMS. No Federal funds at all?

Mr. CARITHERS. No; the mortgages, I might say, are insured under FHA.

Senator ANDERSON. This is no different from any other commercial venture, Del Webb's Sunshine City or Horizon Cities.

Mr. CARITHERS. We think it is quite different, Senator Anderson.

Senator ANDERSON. It is?

Mr. CARITHERS. Because of the medical program and a number of other unique features.

Senator ANDERSON. Couldn't Del Webb provide it for his Sunshine Cities.

Mr. CARITHERS. This is a cooperative nonprofit venture for people who do it themselves. We think had this program been in operation perhaps 15 years before this year, rather than just the 8 that it has, perhaps it might have provided an adequate answer other than Federal legislation and health care?

Senator ANDERSON. Senator Curtis?

Senator WILLIAMS. The point I was trying to get, if I may, was that this is a private enterprise project; it is not exactly a nonprofit project, although one phase of it may be nonprofit, and we now find that it is federally financed.

Mr. CARITHERS. Yes; the operation——

Senator WILLIAMS. But let's face it—it is a supposedly planned profitable operation.

Mr. CARITHERS. Well, I would certainly assume the Rossmoor Corp. would, in building the project, make a profit. But once the community is turned over to the people and the Leisure World Foundation, it is operated as a nonprofit corporation.

Dr. WERGELAND. The Leisure World Foundation is the management agency of the nonprofit corporation.

Senator WILLIAMS. I understand.

Do these payments stay at $180 or——

Mr. CARITHERS. The budget is developed by the Leisure World Foundation each year.

Senator WILLIAMS. How long does it take with these payments before the man owns his property?

Mr. CARITHERS. I think they are set up on 20-year loans. I would have to qualify this. I am not exactly certain.

Senator WILLIAMS. But at the end of that period it would be paid off?

Mr. CARITHERS. Yes, sir. I should clarify for the record, Senator Williams——

Senator WILLIAMS. I just want to find out how it operates.

Mr. CARITHERS. It is possible that a person can come in and pay cash for his unit. I just wanted to clarify that.

Dr. WERGELAND. Under certain circumstances.

Mr. CARITHERS. He can come in and pay cash. Then his monthly payment would cover, instead of principal and interest on his mortgage, the taxes and costs of all the other community services which he cooperatively participates in.

Senator WILLIAMS. Yes.

Now, how much of the monthly payment is represented by the hospital association for medical care?

Mr. CARITHERS. This varies from $11 per unit per month in one community to a maximum of approximately $31. When we say per unit per month, remember this is for a man and wife. It happens to be on a unit basis but it covers a man and a wife in the unit.

Senator WILLIAMS. That is around $30 per month for medical and hospitalization.

Mr. CARITHERS. That is right.

Dr. WERGELAND. Two people in each unit.

Senator ANDERSON. $6 a month would be a bargain, $3 a month would be an even greater bargain.

Dr. WERGELAND. Yes, overlooking the deductibles, of course.

Senator WILLIAMS. Assuming this bill passes, it would be absorbing a part of the costs which are now being borne by the fund.

Would your costs be reduced proportionately?

Mr. CARITHERS. We would certainly anticipate this would be our way of adjusting to the program. It would make it easier for our residents in their monthly payments. It would be reduced.

Senator WILLIAMS. If that were not true, it would mean that they would be paying a part of the cost and therefore paying double.

Mr. CARITHERS. Oh, yes; which would be—well, they wouldn't do it.

Senator ANDERSON. Thank you very much.

Dr. WERGELAND. You are welcome, sir.

Thank you very much.

Senator ANDERSON. Is Senator Cooper here?

Senator, do you desire to present one of the witnesses who is going to appear here this morning?

Dr. Massie, we are going to break the lineup a little bit.

We will ask Senator Cooper to present you, if you don't mind.

Senator COOPER. Thank you, Mr. Chairman.

I appreciate very much your permitting Dr. Massie to testify. I will say Dr. Massie is a very able and distinguished physician of Kentucky, and for a number of years he has been chairman of the Rehabilitation Committee of the Kentucky Medical Association.

STATEMENT OF DR. W. K. MASSIE, CHAIRMAN, KENTUCKY MEDICAL REHABILITATION COMMITTEE

Dr. MASSIE. Mr. Chairman, and members of the committee, I am Dr. W. K. Massie, an orthopedic surgeon from Lexington, Ky., and

and am appearing here today in my capacity as chairman of the Kentucky Medical Rehabilitation Committee. I would like to confine my remarks, however, to section 303, title 3, at page 176 (disability insurance benefits).

As a rehabilitation committee, we have been concerned with all actors which enhance or retard the return of a disabled worker to a gainful occupation. Rehabilitation which does not terminate in reemployment is futile and all funds thus expended wasted.

We must, therefore, scrutinize carefully any proposed legislation which might have the effect of negating such rehabilitation.

To date, social security is available only to permanently totally disabled workers. Under section 303, H.R. 6675, such payments could be made to workers temporarily or permanently totally disabled for 6 consecutive months. The objective of the section appears to be the provision of speedier benefits for the temporarily or permanently disabled worker whether or not covered by workmen's compensation benefits. This admittedly increases tremendously the expenditure from the disability trust fund, but with this we are not concerned. The effect which these regular payments—often simultaneously with workmen's compensation payments—have on the incentive of a worker to cooperate fully with a provided rehabilitation service is certainly a negative one.

Should it serve to convert even a small percentage of temporarily disabled workers into permanently disabled ones by stimulating their resistance to rehabilitation, its deleterious effects, it seems, would outweight its advantages. Rehabilitation is as often influenced by socioeconomic factors as physical ones. Just as no physical fitness program can alter the conditioning of the populace without individual participation of its members, elaborate outlays for rehabiliation will not increase the work tolerance of a single apathetic worker.

The effect of section 303 would be most devastating in just those low income, frequently single industry areas. Such areas provide little choice to the patient but to return to his original occupation. To return a heavy laborer with a temporarily disabling backache to his job requires the active cooperation of the workers and often the employers.

Rehabilitation rarely restores the work tolerance to the preinjury level. Usually the worker must return to work on a temporarily partial disability basis which is rapidly converted to unrestricted activity by participation in a familiar labor.

If the work is scarce and the workers many, is there much pressure on an employer to rehire a temporarily disabled worker when he knows the worker is well cared for under a program other than workman's compensation?

Social security disability benefits, unlike many welfare programs, are administered on an all-or-none basis—either the worker is totally disabled or he is not covered. This has a paralyzing effect on rehabilitation cooperation since the worker will not return to work on a temporary partial disability status.

Finally, the full force of discouragement is brought to bear on the worker with the best prognosis for full recovery. Unlike the work disabled by psychoneurosis or cardiovascular disease, the worker injured on the job and covered by workmen's compensation is more likely to

be restored to full capacity or left with a minor permanent impairment compatible with his original work. However, encouraged by dual compensation he may be recalcitrant to all rehabilitation efforts.

If the objective, then, is to return a worker to active work status in the shortest possible time, recognizing this to be the optimum mental and physical therapy, then we would request that the committee give serious attention to Section 303. We believe it should be deleted in its entirety, since its deleterious effects seem to outweigh its advantages. If it should only be modified, certainly we would hope that it will be amended to preclude the payment of dual compensation.

We appreciate the opportunity to express our views before this committee.

Senator ANDERSON. Thank you Dr. Massie.

This is a section which has been very carefully discussed as we have gone along. I think the majority of the witnesses have all agreed with you on this section, and I will say to you also that the House in putting it in also provided for a review which is to be finished by December 31, 1966. It is possible that it is going to be rapidly speeded up, and there are members of our committee who are in favor of dropping the section entirely as you suggest.

I want to bring you that slight ray of hope.

Dr. MASSIE. Thank you, sir.

Senator ANDERSON. Senator Talmadge?

Senator Curtis?

Senator CURTIS. Doctor, the rehabilitating process, which you propose here is really best for the injured or ill worker, isn't it?

Dr. MASSIE. Sir, we feel that the best possible thing for a worker is to work. He is more satisfied and he is happier, but he does not understand this.

Senator CURTIS. But after he gets over the hump and is rehabilitated?

Dr. MASSIE. It is best for him.

Senator CURTIS. What has been your observation as to that worker, and his family and the family relationship that it has been a good thing?

Dr. MASSIE. Yes, sir.

Senator CURTIS. Much better than to be shelved and be compensated for a disability than he can overcome?

Dr. MASSIE. I think this is unquestionable. That is right.

Senator CURTIS. How successful is this business of rehabilitation? Are a lot of people rehabilitated?

Dr. MASSIE. Well, sir, this is what brought on my concern in this section of this bill. In our State currently it is interpreted that a man totally unable to return to his original occupation is totally and permanently disabled, and since this interpretation of our workmen's compensation has been in effect, which has been not more than 5 years, our ability to get these workers back to work has been so tremendously curtailed that it has seemed almost a hopeless problem to rehabilitate them.

Prior to this, when they would go back on a limited partial duty status to some different job, they were willing to return to work, and it is this which was a most important factor.

Senator CURTIS. I won't take a lot of time here. In other words, your opinion is that rehabilitation, if properly handled, and the incentives are all directed toward rehabilitation that it is a very successful process and helps a lot of people?

Dr. MASSIE. Yes, sir; if they have the incentive, yes, sir.

Senator CURTIS. That is all.

Senator ANDERSON. Thank you very much, Doctor.

Dr. Grady V. Lake.

Senator TALMADGE. Mr. Chairman, it is a great privilege and pleasure to me to welcome to our committee my old friend and constituent, Dr. Grady V. Lake, of Atlanta, Ga.

STATEMENT OF DR. GRADY V. LAKE, MEMBER, BOARD OF CONTROL, INTERNATIONAL CHIROPRACTORS ASSOCIATION; ACCOMPANIED BY JOSEPH P. ADAMS, WASHINGTON, D.C., COUNSEL

Dr. LAKE. Thank you, Senator Talmadge.

Senator ANDERSON. We are very glad to have you here and appreciate your coming.

Dr. LAKE. Thank you, sir.

Senator Anderson, Mr. Chairman and distinguished members of the Finance Committee, I am Dr. Grady V. Lake, of Atlanta, Ga., and I am a practicing chiropractor and I have practiced my profession in Atlanta for almost 20 years and appear here today on behalf of the International Chiropractors Association, a nonprofit professional association of thousands of practicing chiropractors throughout the United States, with headquarters in Davenport, Iowa, 741 Brady Street. Accompanying me here today is our Washington, D.C., counsel, Brig. Gen. Joseph P. Adams.

First, I wish to express the appreciation to the committee for making time available to call attention to the significant fact that H.R. 6675 in its present form does not fully permit the eligible individuals who qualify for benefits to use or employ chiropractic services.

We wish to urge that the people who are to be the beneficiaries of this legislation should have the freedom to choose the doctor and the method of health services of their choice; that those who are chiropractic patients should not be discriminated against.

We are not involved here with any considerations of the relative merits of one system of healing versus another system of healing. Nor are we concerned with legal recognition of chiropractic—that matter is for the several States to consider, and 47 of them have granted legal status to the chiropractic profession, the second largest healing art in the United States today.

Today's doctor of chiropractic must have at least a high school education prior to entry into chiropractic college, and with only one or two exceptions, he must obtain 4 inresidence years of chiropractic education before making application to the State board of his choice.

Additionally, about one-half of the States today require 1 or 2 years of preprofessional college education in addition to high school and the 4 years of chiropractic education. Moreover, about one-half of the States require the prospective chiropractor to take the same basic science examinations given to prospective members of the other healing arts.

Most workmen's compensation laws recognize the chiropractor's services, and several hundred insurance companies recognize such services in their policies, or by administrative action. Moreover, many doctors of chiropractic obtained their chiropractic education as a direct result and benefit of participating under the "GI bill of rights" education opportunities.

Additionally, the Kerr-Mills bill recognized all members of the licensed healing arts, and this is recognized in the present legislation in section 1905 (6) and (14), page 143. Members of the chiropractic profession number about 20,000, and care for upward of 3 million patients per year. These patients are from all walks of life and most participate in some form or forms of health insurance.

Again, we would call to your attention that section 1802 of the present bill at page 9 guarantees the patient's freedom of choice of health services. It is respectfully submitted that this freedom is not complete or available in fact unless the patient has the choice of the services of all or any of the healing arts.

With this in mind, therefore, we respectfully submit for your favorable consideration the following revised language to be inserted on page 82 of H.R. 6675, section 1861(r) under definition of a "physician":

> The term "physician," when used in connection with the performance of any function or action, means an individual licensed to practice any of the healing arts within the scope of his practice, as defined by the State in which he performs such function or action.

We submit this language be inserted in place of the present language of H.R. 6675.

Specifically, it is most important at this point in the testimony to relate that a vice president of the Metropolitan Life Insurance Co. during the week of May 3, 1965, advised the International Chiropractors Association that—

> although Metropolitan has consistently been honoring the claims of chiropractors, they would find themselves in the very embarrassing position of not being able to reimburse for chiropractic care if they were to become one of the insurance carrier "administrators" of the Medicare plan if it is passed in its present form because the definition of a "physician" does not include chiropractic.

This objective statement from a potential insurance carrier participant is the best example that could be offered this committee to indicate the dire results facing the chiropractic profession from the present discriminatory language contained in the definition of physician. It is assumed that the existing discrimination is inadvertent and arises from a failure to understand the legislative language needs of chiropractic to accomplish inclusion under medicare and that such discriminatory language will be eliminated by the adoption of amendments proposed herein.

Also, to insure fair and adequate recognition of all healing arts under this legislation we respectfully suggest for your consideration the following additional wording to be added to section 1868(a), page 99, at line 14 and at line 18.

At line 14 following the word "medicine" we suggest the additional wording "and the other healing arts."

Further, at line 18 following the ending of the word "physicians," which began on line 17, we suggest additional wording, "as defined in section 1861(r)."

We feel that these suggested amendments to the present proposal will bring the bill into line with the intent of section 1802 of the legislation, "free choice by patient guaranteed," and will afford the Nation an example of general legislation in the health care field which will not be subject to the charge of special interest legislation.

Further, it will provide all who will come under the benefits of this legislation with the right to fully participate in its benefits, an objective shared by all who support the legislation.

We thank you very much for your interest and kind consideration and understanding of our position.

Senator ANDERSON. Senator Talmadge?

Senator TALMADGE. Dr. Lake, as I understand your testimony, while the bill seeks to grant freedom of choice to any patient for any doctor, it does not spell out in detail in the bill that when you refer to a doctor you mean any medical doctor or healing science or art that has been recognized by State law and licensed as such to do business within that State.

Dr. LAKE. Yes, sir. It does omit this fact. I don't think it was intentional in the drafting of the bill, but it does omit it, and it defines "physician" as a practitioner of medicine, therefore, leaving out the other forms of healing which a large segment of the population, of course, as you know, use from time to time.

Senator TALMADGE. You think in keeping with the patient's desire to have freedom of choice to select his own doctor, he should have the right to select whoever has been licensed within the State to practice in that art or profession?

Dr. LAKE. Yes, sir; we feel definitely that this freedom should be granted to our people that would be covered by this legislation.

Senator TALMADGE. I have no further questions.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. Your first amendment is one that would permit a beneficiary to avail himself of the services of a chiropractor; isn't that right?

Dr. LAKE. That is correct, sir.

Senator CURTIS. What you propose in the second instance relates to membership on the National Medical Review Committee.

Dr. LAKE. Our attorney could answer that possibly better than I could. Attorney Adams, if you will.

Mr. ADAMS. It was my impression, Senator, that the minor recommendations for amendment of the statement were necessary, assuming that the principal amendment was granted, to the description of the word "physician" and in other words, there are two minor recommendations being made here, that the words "and the other healing arts" should follow, after the word "medicine."

Senator CURTIS. But section 1868 relates to the National Medical Review Committee. It begins by saying:

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.

And after the word "medicine"——

Mr. ADAMS. Yes, sir.

Senator CURTIS. Then it is true that your amendments on page 4 relate to the qualifications of members for the National Medical Review Committee?

Mr. ADAMS. Yes, sir; Senator Curtis.

Senator CURTIS. And your first amendment relates to the right of a beneficiary without question to choose a chiropractor?

Mr. ADAMS. Yes, sir.

Senator CURTIS. That is all.

Mr. ADAMS. And more significantly, as we pointed out, Senator, that these insurance companies, especially the one that is mentioned, have formally advised the association, the International Chiropractors Association that should they become one of the carriers in the plan they would not be able to reimburse for chiropractic services under the present language of the bill describing a physician.

Senator CURTIS. That relates to your first amendment.

Mr. ADAMS. Yes, sir.

Senator ANDERSON. Thank you very much, Dr. Lake.

We appreciate your coming here.

Dr. LAKE. Thank you, sir.

Senator ANDERSON. Dr. Conforti.

STATEMENT OF DR. JAMES A. CONFORTI, PRESIDENT, AMERICAN PODIATRY ASSOCIATION; ACCOMPANIED BY DR. SEWARD P. NYMAN, EXECUTIVE DIRECTOR, AMERICAN PODIATRY ASSOCIATION

Dr. CONFORTI. Mr. Chairman and members of the committee, I am James A. Conforti, president of the American Podiatry Association, a doctor of podiatry in private practice in Bedford, Ohio, and head of the podiatry department at the Hawthornden State Hospital.

I have with me Dr. Seward P. Nyman, executive director of the American Podiatry Association.

The American Podiatry Association is a voluntary nonprofit organization established in 1912 and composed of 52 component societies, 1 in each State, the District of Columbia, and Puerto Rico.

Since 1958, the American Podiatry Association in statements to the Congress has consistently favored a program to provide health care for older people. In our statement last year, we pointed out that an effective program should include provisions for doctors' services as well as protection to cover the costs of hospitalization.

This position was reaffirmed on January 24 of this year in a statement made by our board of trustees and we are pleased to note that the revised bill passed by the House contains these provisions.

This statement also urges that the Congress should provide older people the needed services of podiatrists for covered benefits. While several of the measures introduced in the House did make provisions for this care, we regret that the revised bill did not retain this language.

The largest team of health personnel and facilities ever considered will be necessary to provide the services for this program. To assist with this effort, the Nation's podiatrists are ready to do their part.

A survey in 1964 of the over 8,000 podiatrists in the United States indicates that 73 percent have institutional affiliations such as hospitals, clinics, nursing homes and homes for the aged.

Approximately 40 percent of the patients treated by podiatrists are over 64 and these older people have three times the incidence of foot problems as the general population.

In Philadelphia, the Public Health Service-supported podiatric health educational, screening, and treatment program appropriately called, "keep them walking," has attracted over 1,500 older persons. An average of more than 12 foot conditions per geriatric patient has been revealed and many previously unrecognized chronic diseases have been diagnosed.

The Department of Public Health of the District of Columbia in providing the services of podiatrists as part of its medical assistance for the aged plan, commented: "Foot problems and the resulting difficulty in walking are widely prevalent among the aged. Such disability contributes to accidents and has a deleterious effect upon their physical and mental health. Only a minimum of podiatry care is available to the medically indigent in the District of Columbia. The Department of Public Health will establish several specialized clinics to examine and treat foot conditions of the eligible aged. * * * Home podiatry services for treatment of serious foot conditions which are common to these infirmed and ill-aged persons will be expanded."

Mr. Chairman, these hearings offer an opportunity to review our experience with two other important health care programs.

Reference is made to the Federal employees health benefits plans and the medical assistance to the aged programs. The legislation in both cases did not specifically include or exclude the services of podiatrists. This decision was left to administrative agencies.

In the case of the health care program for active and retired Federal workers, the service benefit plan administered by Blue Cross and Blue Shield define "physician" as a doctor of medicine, doctor of osteopathy, doctor of dental surgery, and doctor of podiatry. The indemnity benefit plan also defines "doctor" in a similar manner. Other health plans for retired people also include the services of podiatrists for their subscribers.

In this regard, an official of a large insurance company contacted us with his concern for what appears to be a difficult if not impossible administrative problem. He cited the example of a couple, one of whom is over 65 and both are presently subscribers to a health plan. When one of them participates in the proposed program the administrators are faced with the dilemma of telling one member of the family that podiatry services are no longer covered while at the same time continuing to recognize such services for the other member of the family.

In the case of the medical assistance for the aged or Kerr-Mills program, implementation was left for interpretation by the States. In only 16 States and the District of Columbia do such plans provide for the services of podiatrists to older people who are eligible for health care benefits. It is our observation that assuring such persons of the services of podiatrists should not be considered a detail to be resolved after enactment of the statute. We have this concern for these older people following our study of the provisions of H.R. 6675.

Presently, the definition of "physician" referred to in H.R. 6675 includes only the medical doctor and osteopath. Since podiatrists are licensed in every State to treat the foot by medical and surgical means, it is our recommendation that consideration be given to the attached amendments to H.R. 6675 (exhibit 1) so that older people may be assured of the services of podiatrists as part of this most important program and that they may continue to have the freedom to select the doctor of their choice.

Mr. Chairman, I appreciate the opportunity to appear before your committee to express podiatry's concern for health care of the aged and to present its views and recommendations on the program under consideration. I will be pleased to answer any questions at this time.

(The exhibit referred to follows:)

EXHIBIT 1

Amendments to H.R. 6675

Page 123, after line 19, insert following new section:

"DEFINITION OF 'PHYSICIAN' AND 'HOSPITALIZATION'

"SEC. 108. Section 1101(a)(7) of the Social Security Act is amended by striking out 'osteopathic practitioners or the services of osteopathic practitioners and hospitals' and inserting in lieu thereof 'osteopathic practitioners and podiatrists, or the services of osteopathic practitioners and podiatrists and osteopathic and podiatric hospitals,'."

Redesignate the succeeding section and amend the table of sections accordingly.

Conforming amendments

Page 64, after "osteopathic" in line 19 insert "or podiatric" and after "Association" in line 21 insert "or the American Podiatry Association Council on Education, as the case may be."

Page 92, line 8, after "Association" insert ", the American Podiatry Association,".

Senator ANDERSON. Thank you very much.

Senator Curtis?

Senator CURTIS. It is your opinion that what you want done is to change the definition of a physician?

Dr. CONFROTI. Yes, sir. We would like to have it conform with prior definitions of "physician" where it includes doctor of medicine, doctor of osteopathy, doctor of dental surgery, and doctor of podiatry.

We like to feel that the definition should be uniform throughout the Federal Government.

Senator CURTIS. I believe the definition is:

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 sec. 1101(a)(7)).

And that says the term—

Physician, medical care, and hospitalization include osteopathy practitioners or the services of osteopathic practitioners as defined by State law.

Are not the members of your profession legally authorized to practice medicine and surgery?

Dr. CONFORTI. Yes; they are legally authorized to practice medicine and surgery. But unless the definition recognizes that we actually practice medicine and surgery our services will not be included. Our degrees are not that of the M.D. Just as in dentistry, the degree is

doctory of dental surgery, we have doctor of podiatry or doctor of surgical podiatry. It is not spelled out clearly enough.

Senator CURTIS. Well now, do holders of the degree of doctor of medicine treat the feet?

Dr. CONFORTI. Many of them do. I doubt if many psychiatrists or other people in many specialties within the medical field pay much attention. Their license, of course, qualifies them to treat any part of the body with or without qualification in one of the specialties.

Senator CURTIS. What does your license provide?

Dr. CONFORTI. I beg your pardon, sir?

Senator CURTIS. What does your license provide?

Dr. CONFORTI. May I read a typical definition to you?

Senator CURTIS. Yes, please.

Dr. CONFORTI. In the District of Columbia:

The surgical, medical or mechanical treatment of any ailment of the human foot except the amputation of the foot or any of the toes and also except the use of an anesthetic other than a local one.

This is one of the definitions.

Senator CURTIS. You are quite sure that without an amendment you are outside this bill?

Dr. CONFORTI. Yes, sir.

We feel that the aged citizens of our Nation could, by the enactment of this legisaltion, as it now reads, be deprived of an important part of their total health care through the elimination of podiatry services.

Senator CURTIS. What is your situation with respect to private insurance? Do insurance companies employ you?

Dr. CONFORTI. Yes. We are recognized by most insurance firms, and Dr. Nyman, do you have the number of States that cover podiatrists under Blue Cross, Blue Shield or just Blue Shield, let us say? There are 19 States in which Blue Shield does pay for podiatric services that are covered in their schedule of payments.

Senator CURTIS. Are they included in Kerr-Mills?

Dr. CONFORTI. In 16 States they are included in Kerr-Mills.

Senator CURTIS. I mean so far as the Federal act is concerned.

Dr. CONFORTI. Not by name; no.

Senator CURTIS. But it is permitted?

Dr. CONFORTI. This is left up to the administration in the State that utilizes the Kerr-Mills legislation.

Senator CURTIS. I am not suggesting language, I am just asking a question. If it was left to individuals licensed in the several States to deal with health, that would put you in in how many States?

Dr. CONFORTI. Well, I think this would be a very difficult question to answer precisely.

Senator CURTIS. Are there any States in which you are not licensed to do business?

Dr. CONFORTI. No; all States, the District of Columbia, Puerto Rico, the 50 States all have licensure laws for podiatrists.

Senator CURTIS. Yes.

In general what do they require so far as education preparation is concerned?

Dr. CONFORTI. Following high school graduation the prerequisite for entrance into any podiatry college today is 2 years of approved premedical college and 4 years of podiatry college. There are some States

that also require a 1-year internship in addition to the 4-year program leading to the degree of doctor of podiatry, so it is a total of 6 to 7 years.

Senator CURTIS. At the present time none of them require less than 2 years of preprofessional training on the college level and 4 years of college?

Dr. CONFORTI. There may be some State laws which are not clear on that or that may only require 1 year of college, but you must have 2 years of college to qualify for entrance into a podiatry college.

Senator CURTIS. I see. How long have the colleges required that?

Dr. CONFORTI. Well, the first colleges that set up a 6-year program, I believe, started in 1939; am I correct, Dr. Nyman, and the last ones required it in 1964.

Senator CURTIS. For how long a time have they been including 4 years professional training?

Dr. CONFORTI. I think for a minimum of 20 years.

Senator CURTIS. That is all.

Senator ANDERSON. Thank you very much. We will meet again tomorrow morning at 10 o'clock.

Dr. CONFORTI. Thank you very much for the opportunity to be heard.

(Whereupon, at 12:15 p.m., the committee recessed to reconvene at 10 a.m., Thursday, May 13, 1965.)

SOCIAL SECURITY

THURSDAY, MAY 13, 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 Harry Flood Byrd, presiding.

Present: Senators Byrd, Anderson, Long, Douglas, Talmadge, Williams, Carlson, Curtis, Morton, and Dirksen.

Also present: Elizabeth B. Springer, chief clerk.

The CHAIRMAN. The committee will come to order.

The first witness is Dr. Austin Smith.

STATEMENT OF AUSTIN SMITH, M.D., PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION; ACCOMPANIED BY DR. THEODORE G. KLUMPP AND C. JOSEPH STETLER

Dr. SMITH. Mr. Chairman and members of the committee, my name is Smith, and there are with me today Dr. Klumpp on my right, and Mr. Stetler on my left.

If I may conserve your time by simply directing your attention to the first two or three pages of our prepared testimony, the identification of these gentlemen and of myself will be found there.

I would like to express appreciation, on behalf of ourselves and particularly of the association, for the opportunities to appear and I will try to show our thanks by summarizing our statement. I would like to cover a few points just briefly on some of the pages, hurriedly go through them and then hopefully be prepared to answer questions that you and your colleagues may have.

The reason the Pharmaceutical Manufacturers Association asked for the opportunity to appear before you is because of its long interest in what we call prescription drugs, drugs that are available only on prescription, and it represents, as you will find on the pages of the prepared statement, a substantial, in fact 90 percent or more of prescription drug business in the United States.

Furthermore, we have been concerned, through the association, not with prices or marketing practices of the individual members, but the quality, the availability of drugs in general, and their benefits.

We have found that in our studies, as have practicing physicians, that the changes that are occurring in the drug field today are dramatic and rapid. There is some indication of the speed with which this change is occurring. This is a matter of considerable importance when we consider the two sections of the bill, to which we would address ourselves today. I might add an observation since drugs are used in hos-

pitals, and the bill under discussion today refers to a large extent to hospital care, that three-quarters of the drugs now available in hospitals were not available for hospital use, or any use even 10 years ago.

Our interest in this bill has been of long standing. We did present a statement before the House, but as you know, there weren't any hearings so this appearance presents, the first opportunity for the Pharmaceutical Manufacturers Association to discuss publicly our views on these two provisions.

One deals in general with the availability of drugs for people who would be embraced under the so-called medicare bill. The other has to do with what might be called reasonable costs.

Section 1861(t) defines drugs and biologicals, in a way that limits the drugs that can be available to those listed in the cited compendiums or to the use of hospital formulary committees. Unfortunately, we believe there wasn't a proper understanding of how limiting this language might be, and so we would like to direct your attention, and the members of your committee to some aspects of this limitation which we think should not be ignored.

Dr. Klumpp and I, for many years, have been associated with the workings of the United States Pharmacopeia. We are also familiar with the activities of another body which made available a listing of drugs, known as New and Non-Official Remedies, which is now to be superseded by another publication to be known as New Drugs. So we speak with some knowledge of the slowness which sometimes occurs when drugs are admitted to a compendium or are adopted by a committee. Committees of medicine work slowly, and we are concerned about this.

So, on several of the pages of our prepared statement, there is reference to the United States Pharmacopeia, the speed with which it moves, how it functions. There is also reference to the National Formulary, which is another of the compendiums which is mentioned in the legislation.

The same is true for New Drugs, one of the other compendiums that is mentioned and Accepted Dental Remedies.

Now, I would like to direct your attention, Mr. Chairman, to some findings that have been obtained by the Pharmaceutical Manufacturers Association and made for the association.

As I have indicated very briefly so far, there is often considerable delay concerning the inclusion of the newer remedies in the compendiums cited because of the need for committee action.

What this could mean is indicated in the statement which we are appending as exhibit 1. Although the statement speaks for itself, there are a couple of examples to which I could direct your attention. One concerns cortisone because this a very important drug in the older age group. This product was available for about 2 years before it was included in New and Non-Official Drugs soon to be known as New Drugs. The same situation existed for chlorathiazide, which is extremely important in the control of certain kinds of heart disease.

These delays in the availability of important new drugs, we feel would be most regrettable as far as patient care is concerned.

Another indication of the practical limitations of relying on compendiums is provided in a study that has just been completed for us, and made available only a few days ago.

If I may have your permission, Mr. Chairman, I would like to introduce this report into the record. I will give a copy to the individual in charge of the transcript.

The CHAIRMAN. Without objection, it will be included in the record.

Dr. SMITH. It is a study that indicates that of the 200 most prescribed medications in 1964, 91 are not listed in the compendiums referred to in the legislation now under consideration. This would mean then that the elderly, under the medicare bill as now proposed, would run a chance of being limited to only about 55 percent of the 200 most frequently used drugs today.

Now, I might just pause long enough to emphasive how important these drugs are. They include lifesaving antibiotics, excellent pain relievers, and drugs used for depression, heart disease, circulatory disorders, and cancer. All of these drugs are of great concern to those of us in the medical profession and drug manufacturers for treating the older age group.

Now, one thing that perhaps may sometimes be overlooked is that these drugs that would not be included under this limitation are ones that have been screened and approved by the Food and Drug Administration, I use the word "approved" now in view of the recent amendments to the Federal law, and I think it is used in proper context in this testimony.

These products, and many more, are on the market in conformance with various Federal laws that have been designed and have been amended recently to oversee the soundness of the Nation's drug supply and particularly the safety and the efficacy of the drugs that are now used by the medical profession and others.

There is another limitation in section 1861(t) that is concerned with the control that could be exerted by drug committees of hospitals and nursing homes.

In my statement there is mention of a special report sponsored by the Public Health Service and conducted by the American Society of Hospital Pharmacists which shows that many hospitals do not have these screening committees. Of the 7,000-odd hospitals that are available in the Nation today there are not more than 1,085 that have active pharmacy and therapeutic committees.

Thus the survey indicates that in 85 percent of the hospitals there are no committees that could take advantage of whatever leeway the bill might provide now in the selection of drugs.

And, of course, in nursing homes there are even fewer of these committees.

One other aspect to which we would like to direct attention has to do with drugs in combination. In the statement there is an example of what would happen if a hospital were to use two drugs which we shall call A and B, in combination and what would happen if they were prescribed separately.

If they were put in a single capsule the patient would have to pay under the present wording.

Now, the importance of this point, we believe, is clearly illustrated by the fact that of the 50 most prescribed drugs last year there are 14 that are combination products, in other words, products which would not be available under this bill. Why? Well, the ingredients are not available except in bulk form so that the hospital would have to

compound, make these things, and this would add considerable to the effort and to the cost. An example of the cost factor is mentioned in the statement if one of the combinations were to be prescribed in separate doses rather than in a single capsule. It would add more than 500 percent to the cost of the medication if prescribed separately, as I have mentioned.

For the reasons cited we believe this language to which we have been directing attention in section 1861(t) is unduly restrictive. We think its effect would operate to the disadvantage of prescribing physicians, patients and the Government which would foot the bill.

Thus we hope the committee will revise this section so that the elderly can obtain the same treatment under the bill that other hospital and nursing home patients enjoy, and which all equally deserve.

We have just a couple of proposals whereby this could be effected, recognizing that there are other ways of correcting the situation. We would like to suggest wording as noted in the statement as examples.

The first in effect says that if the drug is ordered or prescribed by attending physicians on the medical staffs of hospitals or nursing homes it should be included.

The other would, in effect, say if something that was made available in interstate commerce under the provisions of the Federal Food, Drug, and Cosmetic Act it should be eligible.

We indicate the second point to which we would like to direct the attention of the members of the committee, Mr. Chairman. This point has to do with the definition of reasonable costs. Section 1814(b) and 1861(b), section 1, which deal with reimbursable costs, contain some wording to which I would direct your attention. This wording reads:

> 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—

The section referred to outlines the authority of the Secretary of HEW to promulgate regulations specifying methods to determine the reasonable cost of services. This language as we interpret it is all encompassing in the authority that it gives to the Secretary.

It is our impression, an impression gained from things that have happened in countries elsewhere in the world, that such authority might lead to exclusion from this program of drugs on the basis of costs alone irrespective of their medical value.

I might say we are quite aware of the concern of the House Committee on Ways and Means when it considered the perplexity of determining costs and we know what your problem might be. However, we would direct your attention to the problems that would arise if this authority were to be abused.

We think that this provision could result in a very complex and expensive system for Government, and at the same time make it difficult for attending physicians to select the drugs that their experience and training and judgment suggest. I am sure this is not the intent of those who are sponsoring the bill.

I would suspect they didn't have in mind seting up two classes of citizens, those 65 and over and those under, or those in medicare and those outside of medicare.

We believe that the only reasonable cost is the one that is determined to be the normal or usual price or charge which the institution

usually places upon the service to other than those in the program covered by these regulations. In other words, all people should be treated equally.

We think also that because prices and costs, particularly labor costs vary from one area to another, this variation must be recognized and not be covered by a general order which would be sweeping for all parts of the country.

Senator Byrd, and members of the committee, this is a very brief presentation of the 20-page statement which was prepared for the record, and about which we would be pleased to try to answer any questions.

I hope that the rapidity with which I covered these pages has emphasized the points which are of concern to us and not obscured them with confusion. We would be pleased, now, sir, to try to answer any questions that you may have.

(The full prepared statement of Dr. Smith follows:)

STATEMENT OF AUSTIN SMITH, M.D., PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION, CONCERNING H.R. 6675

Mr. Chairman and members of the committee, it is a privilege to appear before you today to present the views of the Pharmaceutical Manufacturers Association on H.R. 6675, 89th Congress, a bill establishing a new Federal hospital and related health care program for aged persons.

My name is Austin Smith. I am a physician and president of the Pharmaceutical Manufacturers Association. For some years I was editor and managing publisher of the Journal of the American Medical Association and of other scientific publications sponsored by that association. I am chairman of the board of directors of the U.S. Committee and Council Emissary of the World Medical Association, and have served as executive editor of the World Medical Journal.

I have served in various official capacities for bodies such as the U.S. Pharmacopoeia, medical and other organizations, universities and scientific societies. I am also a member of a number of professional and scientific associations.

I received my degree, M.D., C.M., in 1938 from Queen's University, Ontario, and a master's degree in medical science from the same university in 1940.

I am accompanied by Dr. Theodore G. Klumpp and Mr. C. Joseph Stetler.

Dr. Klumpp is president of Winthrop Laboratories and a member of the board of directors of the Pharmaceutical Manufacturers Association. He was graduated from the Medical School of Harvard University in 1928 and practiced at various hospitals in Boston, Cleveland, and New Haven, where he was on the faculty of the Yale University Medical School. In 1936 he was appointed Chief Medical Officer and in 1938 became Chief of the Drug Division of the U.S. Food and Drug Administration. He served in that capacity until 1941.

He was vice president of the U.S. Pharmacopoeia from 1950 to 1960, when he was reelected to a second term running to 1970. He was Chairman of the Medical Service Task Force of the second Hoover Commission and is presently a member of the Medical Advisory Committee of the Department of Health, Education, and Welfare's Office of Vocational Rehabilitation. In addition, he was Chairman of the Office of Defense Mobilization's Task Force on Employment of the Handicapped. He is a member of the Panel on Aging of the Department of Health, Education, and Welfare, and Chairman of the Subcommittee on Physical Fitness. He is a director of the U.S. Committee of the World Medical Association, a director of the American Heart Association, and chairman of its Committee on Rehabilitation, a member of the American Medical Association and a fellow of the American College of Physicians and of the New York Academy of Medicine.

Mr. Stetler is executive vice president of the Pharmaceutical Manufacturers Association. He was graduated from the Catholic University of America School of Law, and holds LL.B. and LL.M. degrees from that university, which he earned in 1938 and 1940, respectively. A member of the bars of the District of Columbia and the State of Illinois, Mr. Stetler holds membership in the Chicago

Bar Association, the Illinois Bar Association, District of Columbia Bar Association, and the American Bar Association.

From 1935 to 1951 he was with various Government agencies, including the Civil Service Commission, the Social Security Administration, and, as Director of the Legislation and Opinions Service, the War Claims Commission. He was general counsel, director of the Legal and Socioeconomic Division, and director of the Commission on the Cost of Medical Care of the American Medical Association prior to joining PMA, approximately 2 years ago. He has coauthored the books "Doctor and Patient and the Law" and "Handbook of Legal Medicine."

The Pharmaceutical Manufacturers Association is a trade association of 136 manufacturers of prescription drugs and related products, who account for more than 90 percent of the Nation's total prescription drug output. We respectfully invite attention to the historical fact that there has been no important development in recent decades in drug therapy in which member firms of PMA have not played a significant role, either in the discovery of the agent or in defining its utility and making it readily available in useful and dependable form to the medical profession.

Our member firms invent, develop, manufacture, and distribute products which prolong and save life. During the last 30 years, the U.S. drug industry has become the world leader in developing new medicines. Of 604 major new drugs made available since 1941, nearly two-thirds originated in this country, with only a relative handful coming from other than private industrial research. New drugs have been a major factor in bringing about an astonishing reduction in death rates.

The results of these advances can be measured in terms of health, lives, and also dollars. The National Health Education Committee has estimated that the decline in mortality rates since 1937 has added almost $9 billion to the national economy each year. More than 4 million Americans living today would be dead if 1937 death rates had continued. The decline in the number of mental hospital patients below the number predicted 5 years ago has saved approximately $1.8 billion in institutional construction costs alone. Drug treatment for tuberculosis has been so effective that between 1946 and 1961 the number of beds required for tuberculosis patients has declined 35 percent, and many hospitals have been closed or converted to other uses.

Although drugs are not solely responsible for these results, they unquestionably deserve a substantial degree of credit. One statistic alone dramatizes what has happened. Of the more than 775 million prescriptions written in 1964, it is estimated that 70 percent could not have been filled in 1950, for the simple reason that the drugs prescribed were not then in existence.

This revolution is attributable to many factors. One is the enormous research program of the pharmaceutical industry. Since 1949 its annual research and development expenditure has increased eightfold. In 1964 alone, such expenditures were almost $300 million—bringing total industry R. & D. to well over $2 billion since 1950.

In addition, the drug industry has developed testing and quality control techniques that increasingly improve the safety, quality, effectiveness, and uniformity of the product. It is a fact that the Government regulations written to identify sound manufacture for the most part reflect nothing more than a codification of practices and skills developed by the industry itself.

Between the time of discovery in a research laboratory and the day a drug is finally marketed, the average period of further work has been 5 to 6 years. The cost of research and development of a single new drug has been estimated to average $5 million. In a typical year, the industry studies the effects of drugs on about 9 million animals—only the first step in drug testing. Clinical testing on human patients is most critical and requires the highest degree of ability. Throughout the process of experiment, manufacturers do everything possible to assure the collection of all possible information that might bear on the drug's use. In short, this industry recognizes its role of primary responsibility for the quality of the Nation's drug supply, present and future, and takes a genuine interest in the overall health and welfare of the people its drugs are made to benefit.

This longstanding interest in the health of all our people caused us to submit statements to the House Ways and Means Committee in the 87th, 88th, and the present Congresses. However, since no hearings were held on House-passed H.R.

6075, this represents our first opportunity to present, for public discussion, our views on two provisions of the bill which we believe deserve further consideration and revision.

The purpose of our presentation, therefore, is to make our comments to the committee with respect to these provisions, and to suggest possible amendments.

Section 1801(h) of the bill plainly outlines the intent of Congress which proposes that the practice of medicine, including the professional duty and obligation of the physician to choose his patient's treatment on the basis of medical judgment, shall not be interfered with by the Government.

Provisions dealing with the availability of drugs under this bill are in our opinion in discord with the objectives of that section.

In brief, these provisions place definitional restrictions on the drugs which shall be made available to elderly patients under the bill, and include language authorizing a determination of "reasonable costs" which in time could result in Government price fixing in drugs. They are discriminatory, have no demonstrable basis in either good medicine or sound economics, and set up unworkable barriers to physicians in their practice of medicine.

DEFINITION OF THE TERMS "DRUGS" AND "BIOLOGICALS"

The first such provision is section 1861(t) which defines the words "drugs" and "biologicals".[1] Its intent is to limit reimbursable drugs to those listed in certain compendiums—the Pharmacopoeia of the United States, the National Formulary, New Drugs or Accepted Dental Remedies, and to any additional drugs approved by an individual hospital's or nursing home's pharmacy and therapeutics committee, or equivalent body.

In evaluating this definition it is important to remember that the cited compendiums do not purport to list all safe and useful drugs, or even every acceptable dosage form of the drugs they do list. For the convenience of the committee, I shall briefly describe the areas covered by each.

THE PHARMACOPOEIA OF THE UNITED STATES

This publication is known as the "U.S.P." Founded in 1820, the organization that publishes "U.S.P." is formally known as the United States Pharmacopoeial Convention, Inc. It is intended as an authoritative source of minimal standards for those therapeutic substances that are most important, in the opinion of its committee on scope to the best practice and teaching of medicine.

The convention meets every 10 years, and "U.S.P." is revised each 5 years. Interim revisions to the book are issued from time to time.

U.S.P. delegates come from the Nation's accredited colleges of medicine and pharmacy, 7 Federal agencies, the State medical and pharmaceutical associations, and 12 national professional associations of medicine and pharmacy. Altogether, it is possible to have 277 delegates to the U.S.P. Convention. The convention elects a board of trustees to serve for 10 years. It consists of two persons from medicine, two from pharmacy, and two "at large" delegates. In addition, a president, vice president, secretary, and treasurer are elected, also for 10 years.

The most active U.S.P. committee is the committee of revision, chosen at the convention and consisting of 60 experts who represent medicine and pharmacy. A committee on scope of about 20 physicians and pharmacists is normally the body that recommends a drug for inclusion in "U.S.P." The full committee of revision acting with assistance from outside experts, then collects information and develops standards to permit identification of the drug and permissible ranges to establish purity, quality, stability, etc. As the standards are developed, they are circulated for comment to appropriate institutions, until at length an agreeable manuscript is arrived at for inclusion in the book.

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[1] Sec. 1861(t):
"The term 'drugs' and the term 'biologicals,' except for the purposes of subsec. (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."

It is important to recognize the difficulty involved in preparing a U.S.P. entry; procedures employed by the original manufacturer of the product may be far too complex for general use, so that there is frequently much delay before standards suitable for general application can be agreed upon. It is thus quite common for 5 years to pass between the time an important new drug is marketed and the day it can be called a "U.S.P. drug."

"THE NATIONAL FORMULARY"

"N.F." was established in 1888 under the auspices of the American Pharmaceutical Association, the professional organization of pharmacy. The book's early function was to provide formulas and recipes for products in wide use by physicians and pharmacists but not included in the "U.S.P."

However, over the years it has evolved to become a book of standards for drugs which, in the opinion of its committee on admissions, have therapeutic value, regardless of their degree of use in practice. The "N.F." is revised each 5 years, and provision is made for periodic interim revisions when the committee feels a new development is of sufficient significance to warrant publication.

While the "U.S.P." confines itself to agents that it considers of such importance as to be firmly established essentials of medicine, and avoids preparations of similar chemical structure and therapeutic use, "N.F." attempts to consider drugs that have "substantial therapeutic merit," even though their value may not be firmly established. Drugs chemically and therapeutically similar may be included in "N.F."

The process of selection of a drug for "N.F." is not different in a material way from that used by U.S.P. and like the U.S.P., quite a substantial delay in the completion of entries for publication is common.

"NEW DRUGS"

Planned for its first edition in July 1965, "New Drugs" will replace and differ markedly from "New and Nonofficial Drugs" which has been published in basically the same form for 60 years, under the direction of the Council on Drugs of the American Medical Association.

"New Drugs" will contain monographs on nearly all single-active-agent drugs approved for marketing by the U.S. Food and Drug Administration in the last 10 years. It is planned that a revision will be issued every year.

"New Drugs" is intended to provide the physician in practice with a readily usable, concise source of information. However, in announcing the book, AMA has emphasized that it is not going to be a comprehensive book on drug therapy as such. In form, the entries will consist of the council's opinion of a given drug, together with a discussion putting it in context with other available therapy, and summarizing the indications, dosages, side effects, caution, and other information important in its use.

To arrive at an opinion, the council (composed of 13 physicians supported by a staff of 65 in the AMA's Department of Drugs and 380 expert consultants) consults all available information about the drug. The information is supplied by the manufacturer, and includes, in addition to published information from the world medical literature, unpublished data from the company's files that is not available to any other organization except the FDA. While an attempt is made to arrive at an early consensus after a drug is marketed, delays in publication of a council opinion are common, and, as in the case of the official compendia, years may pass before an individual drug is included.

Important as "New Drugs" will be, the council itself has pointed out its limitations, noting that neither this new aid nor any other book now in print will provide even a relatively complete and authoritative reference on all drugs available to and used by the medical profession.

"ACCEPTED DENTAL REMEDIES"

This book is published annually by the American Dental Association, and is presently in its 80th edition.

The book contains descriptions of pharmaceutical and other products that, in the opinion of the American Dental Association Council on Dental Therapeutics, are of "recognized value" or "uncertain status" (the latter is as opposed to articles the council rejects) in the dental practices.

The council consists of 10 dentists, who call upon the advice of 15 consultants in medicine, dentistry, chemistry, and other fields. Their opinion is arrived at from information supplied by manufacturers. In addition to providing the common name of an article, its "U.S.P." or "N.F." status is mentioned, and those brands of the product which the council has approved are mentioned by name.

An article may be listed in "A.D.R." for only 3 years, but the listing is renewable if, in the opinion of the council, it is justified.

The American Dental Association has estimated, as a rough approximation, that an absolute minimum of 6 months would be required from the time a product is marketed to the time the council could make and publish its approval. It was emphasized that such rapid processing of an application for council approval is most rare.

As I have indicated, Mr. Chairman, delay is frequently substantial in the selection and inclusion of drugs in the various references. To gain some understanding of the amount of delay one might expect under these circumstances, we have looked into the time that lapsed between the date a number of very essential drugs were marketed and when they appeared in one of the books the bill recognizes.

The result is attached to my statement as exhibit 1. While the paper speaks for itself, I would point out just one or two examples from it. Please note that cortisone was available about 2 years before it was included in new and nonofficial drugs, soon to be known as new drugs, and that it was marketed for 6 years before there was a "U.S.P." entry for it. You will see that chlorthiazide was marketed 3 years before it was included in the compendia. This drug represented a major breakthrough in the therapy of congestive heart failure. Please note that delays of a year or more happened in the cases of several antibiotics which are fundamental to medical practice today.

A further indication of the practical limitations of relying solely on the compendia is provided in a study of the drugs physicians most frequently prescribe. A copy of this study which was completed for us just a few days ago is being submitted for the record. It indicates that of the 200 most prescribed medications in 1964, 91 are not listed in the compendia referred to in the bill.

That means that the elderly under "medicare" run a chance of being limited to only 55 percent of the 200 most used drugs on the market. Let me emphasize, in addition, that the drugs to be denied them are of extremely high value. Among them are lifesaving antibiotics, pain-relieving compounds, drugs against depression, heart disease, circulatory disorders, arthritis, and cancer. We are talking about antibiotics certified for potency by the Food and Drug Administration, a cancer product that is among the relatively few that have been cleared beyond the experimental stage by FDA; a medically accepted alternate therapy to the scarce and expensive artificial kidney; single-unit dosage forms of drugs in cartridges complete with disposable needles that reduce inhospital cross-infection and are used by 46 percent of the Nation's hospitals.

All of these products, and many more, are on the market in conformance with the various Federal laws designed to oversee the soundness of the Nation's drug supply. This section undercuts and, so far as the aged are concerned, negates in effect the work of the Department of Health, Education, and Welfare in the enforcement of existing law. Under this bill, prescription products that have had the thorough and lengthy consideration of the Food and Drug Administration and on which FDA has categorically given approval for marketing, would not be provided for the aged.

A further limitation imposed on the availability of drugs is the reliance in the bill upon drug committees of hospitals and nursing homes, as a mechanism for broadening the selection of drugs. This is so by virtue of the fact that most hospitals and the vast majority of nursing homes simply do not have committees of this type.

A report entitled "Mirror to Hospital Pharmacy," published in 1964; based on a study sponsored by the U.S. Public Health Service and conducted by the American Society of Hospital Pharmacists provides the latest and most authoritative information in this regard. The report indicates that of the Nation's 7,004 hospitals, not more than 1,085 have "active" pharmacy and therapeutics committees. "Active" is defined as meeting once a year or more. The survey therefore demonstrates that in 85 percent of the hospitals, there is no committee that would take advantage of whatever leeway the bill might provide for the selection of drugs.

Appreciation of the difficulty of maintaining a strict and formal list of drugs is well recognized by the American Society of Hospital Pharmacists. It has noted that even in hospitals that have pharmacy and therapeutics committees, most do not maintain a drug list or formulary; in the case of hospitals without such committees, a full 70 percent have no such list. The society has also said, in the preface to its own formulary, that, "As a rule, the time and effort required for the preparation of such a formulary, and keeping it up to date, is beyond the means of most hospital staffs."

Given the present state of hospital pharmacy and therapeutics committees, it is apparent that the selection of drugs from hospital to hospital will vary in most unscientific way, depending on whether a committee has been formed, whether it has met, and, if so, whether or not it was well constituted and has or can actually reach agreement.

There is one further aspect of this section that bears discussion. It would, as worded, not permit the use of dosage forms of drugs in combination. That is, the hospital might be reimbursed for drug A and drug B, if both are in the compendia and they are prescribed separately. But if the physician writes an order for drug A and drug B in a single capsule, the patient would have to pay for it. The importance of this point is clearly illustrated by the fact that of the 50 most-prescribed drugs, there are 14 that are combination products, products which would not be available, in a practical sense, under this bill. The ingredients for them are not made available except in bulk form, so that the hospital would be required, in effect, to attempt to manufacture a preparation already available in pharmaceutical quality. A 15th combination product included in the top 50 could be prescribed in separate doses that together would equal the single capsule. That product, I might mention, is a broad spectrum antibiotic which is combined with an antifungal preparation that prevents overgrowth of fungi in susceptible patients. Unfortunately, there is no oral formulation of the latter ingredient alone, so that it would have to be administered by mixing it with an appropriate vehicle and then administered by intravenous infusion. In this case our calculations indicate that the cost of this medicine would be increased 551 percent by following the separate-ingredient route as opposed to taking advantage of the combination form.

In considering the types of combination drugs which are included in the list of the 200 most frequently prescribed but which are not included in the compendia cited, it is interesting to review a few specific examples.

(*a*) There is no listing in the compendia for therapeutic vitamin-mineral combinations, which are common therapy following surgery in the aged, and in the presence of debilitating diseases.

(*b*) Drug treatment of high blood pressure is very frequently initiated using a mixture of a diuretic and a hypotensive agent. There are several such products available, and their rationale is widely accepted. They would not be available under this bill.

(*c*) Very substantial numbers of aged persons suffer arthritis, which is commonly treated with cortical hormones and analgesics. Rational combinations of the two are readily available, much employed, but not provided under H.R. 6675.

(*d*) Pernicious anemia is preferably treated with injections of vitamin B_{12}. But when this is difficult or undesirable, oral administration of the vitamin in combination with intrinsic factor concentrate achieves a similar result. But this combination is not recognized in the compendia.

(*e*) A common geriatric problem is senility and cerebral arteriosclerosis, with resultant deterioration in the patient's ability to cope with his environment. De-

pression and agitation are frequently seen in such patients, and it is good medical practice to give them a stimulant combined with a sedative or tranquilizer. Again, no such product is listed.

In light of all the foregoing, I submit, the language of section 1861(t) is unduly restrictive. Its effect would not favor the patient, the physician or the Government. In fact, it would be a serious disadvantage to all three. We hope the committee will revise the section so that the elderly can obtain the same treatment under this bill that other hospital and nursing home patients enjoy, and which they deserve.

This could be accomplished by amending section 1861(t) in one of several ways; one would be to delete the words: "or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of a hospital furnishing such drugs and biologicals," and in lieu thereof insert the words, "or are ordered or prescribed by the attending physicians on the medical staffs of hospitals or nursing homes for the care and treatment of patients,"

Another would be to redraft the section so that any drug or biological made available in accordance with the Federal Food, Drug, and Cosmetic Act, or Public Health Service Act, as amended, would be eligible for inclusion under the program.

Further, provision must be made so that new drugs approved by the appropriate agency of Government for marketing are not unduly withheld from the aged because of administrative or mechanical delays in listing them in appropriate compendia. Thus language should be inserted to permit reimbursement for drugs selected for such books at the time the selection is made.

REASONABLE COST OF SERVICES

The other section of H.R. 6675 on which we offer comment is 1814(b), which, together withm 1861(v)(1), deals with reimbursable costs; 1814(b) reads:

"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)."

Section 1861(v)(1) outlines the authority of the Secretary of Health, Education, and Welfare to promulgate regulations specifying methods to determine the "reasonable cost" of services. The language used is virtually all encompassing in the authority it gives the Secretary in deciding what a reasonable cost is.

It is our impression that such authority might lead to the exclusion from this program of drugs on the basis of cost alone, irrespective of their medical value.

We are aware that the report of the House Committee on Ways and Means on H.R. 6675 reflects understanding of the complexity of determining costs. I note that at page 31 it states, "The cost of hospital services varies widely from one hospital to another and the variations generally reflect differences in quality and intensity of care. The same thing is true with respect to the cost of services of other providers."

It is this point that, in our opinion, needs to be made in the bill itself. The pharmaceutical industry's costs are made up of more than raw materials and the machines to produce dosage forms of drugs. We are the largest private employer of scientists per 1,000 employers of any industry.

Only if the costs involved in conducting research and development, in setting and maintaining standards of quality, in providing services to the professions who distribute and use the products, are considered can an estimation of the reasonableness of cost be meaningful and realistic. It is our opinion that consideration of such factors is good medicine as well as sound economics. The fact that about 95 percent of prescriptions are written calling by name for the products of companies that assume such costs testifies to this point.

In the case of H.R. 6675, an act of a Government agency, under this section could lead to a complex and expensive system and at the same time make it difficult for the attending physician to select the drugs his experience, training, and judgment suggest for the patient. If this occurred, the result would be inconsistent with the bill's announced intent to avoid interfering in the practice of medicine.

The only reasonable price (cost to patient) is one determined as being the normal or usual price or charge which the institution usually places upon a service to other than those in the program covered by these regulations. To do

otherwise would be tantamount to price setting by the Secretary and a denial of the normal market mechanisms. Rates and prices are best set in the framework of the unique circumstances of each local situation and not by fiat from a central agency.

Senator Byrd, and members of the committee, the prescription drug industry is grateful for your kindness in hearing our views on this important legislation. Of course, we are ready to assist you in any possible way as you work to make the bill as sound a piece of legislation as is feasible.

EXPERIENCES OF ESPECIALLY OUTSTANDING PHARMACEUTICALS IN GAINING ACCEPTANCE IN U.S. PHARMACOPOEIA, NATIONAL FORMULARY, AND NEW AND NONOFFICIAL DRUGS

In 1964, the American Medical Association published the final report of its Commission on the Cost of Medical Care, a study begun in 1960 that examined the multiple facets of the economics of medicine.

In the process of evaluating the impact of new drug developments, the commission contacted the 380 consultants to the AMA Council on Drugs to determine the 30 drugs or drug classes which they regarded as the most significant developments in the period 1934–64. While in some cases the consultants named classes of drugs rather than specific agents, sufficient of the latter were named to permit a good sampling of the "key" drugs developed over the last 30 years. From that list the following table can be constructed:

EXHIBIT I

Name of drug	First marketed	Admitted to USP	Admitted to NND
Penicillin sodium	1943	1950	1945
Cortisone acetate	1949	1955	1951
Streptomycin	1945	1950	1948
Isoniazid	1952	1955	1953
Chlorpromazine	1954	1956	1956
Aminosalicylic acid	1948	1955	1951
Isoproternol	1948	1955	1950
Methantheline	1950	1955	1953
Diphenhydramine	1946	1950	1947
Chlorothiazide	1957	1960	1960
Chlortetracycline	1949	1955	1950
Reserpine	1953	1959	1956
Meperidine	1944	1950	1947
Chloramphenicol	1949	1950	1951
Tolbutamide	1957	1960	1958
Chloroquine	1946	1950	1948
Phenylephrine	1934	1950	1935
Triheryphenidyl	1949	1960	1954
Lidocaine [1]	1949	----------	1950

[1] Only lidocaine was listed in the National Formulary. It was admitted in 1955.

TWO HUNDRED LEADING DRUGS

Based on new prescription frequency representing over 60 percent of all new prescriptions in drugstores

(List of products obtained from National Prescription Audit for 1964; R. A. Gosselin & Co., Inc., Dedham, Mass.)

Additional data added and arranged by Paul de Haen, New York, N.Y.

A. Single chemical entities, indicating acceptance by USP XVII, National Formulary XII, effective September 1, 1965. New and Nonofficial Drugs, 1964.

B. Combination products, indicating acceptance by USP XVII, National Formulary XII, effective September 1, 1965. New and Nonofficial drugs, 1964.

April 30, 1965. Corrected copy, May 10, 1965.

200 LEADING DRUGS

Statistical analysis

	Number of products	Percent	Number of products	Percent
Single chemical entities:				
Listed in official compendia	108	90.8		
Not listed in official compendia	11	9.2	119	59.5
Total	119			
Combination products:				
Listed in official compendia (paregoric USP)	1	1.2		
Not listed in official compendia	80	98.8	81	40.5
Total	81			
Total products			200	100.0

NOTE.—All drugs are arranged by the de Haen therapeutic classification and code numbers. Products are ranked under each therapeutic classification in order of new prescription frequency.

Single chemical entities, not listed in official compendium

Therapeutic class number			
125	Pyridium		Warner-Chilcott.
145	Polycillin	1963	Bristol.
230	Valium	1963	Roche.
280	Nitroglycerin		
350	Robitussin	1949	Robins.
355	Sudafed	1958	Burroughs Wellcome.
370	Periactin	1961	Merck, Sharp & Dohme.
390	Synalar	1961	Syntex.
390	Cordran	1961	Lilly.
800	Proloid		Warner-Chilcott.

200 leading drugs

(A) SINGLE CHEMICAL ENTITIES

Product name	Manufacturer	Year introduced	USP XVII	NF XII	NND 1964
015 Analgesics narcotics:					
Demerol	Winthrop	1944	.....	X	
Codeine sulfate	.....	.....	.....	X	
020 Analgesics nonnarcotics:					
Darvon	Lilly	1947	.....	.....	X
Tylenol	McNeil	1955	.....	X	
060 Anthelmintics: Povan	Parke, Davis	1959	X	.....	X
070 Antiarthritics (nonhormonal) including gout: Butazolidin.	Geigy	1952	.....	X	X
080 Anticoagulants: Coumadin sodium	Endo	1954	X	.....	X
090 Anticonvulsants: Dilantin sodium	Parke, Davis	.....	X	.....	
100 Antihistamines:					
Benadryl	....do	1947	X	.....	X
Chlor-Trimeton	Schering	1949	X	.....	X
Teldrin	Smith Kline French	1954	X	.....	X
Dimetane	Robins	1957	.....	X	X
Pyribenzamine	Ciba	1949	X	.....	X
Phenergan	Wyeth	1951	X	.....	
125 Anti-infectives, antibacterials, and antiseptics, urinary:					
Furadantin	Eaton	1953	X	.....	X
Mandelamine	Warner-Chilcott	.....	X	.....	
Furacin	Eaton	1946	.....	X	X
Pyridium	Warner-Chilcott	.....	.....	.....	
130 Anti-infectives, antibacterials and antiseptics, vaginal (trichomonacides): Flagyl.	Searle	1963	.....	.....	X
140 Anti-infectives, antibiotics, broad, and medium spectrum:					
Declomycin	Lederle	1959	.....	X	X
Achromycin V	....do	1957	X	.....	.....
Terramycin	Pfizer	1950	.....	X	.....
Ilosone	Lilly	1959	.....	.....	X
Erythrocin	Abbott	1952	X	.....	.....
Chloromycetin	Parke, Davis	1949	X	.....	X
Tetrex	Bristol	1956	.....	.....	X
Achromycin	Lederle	1953	X	.....	.....
Tetracycline HCl	.....	1950	X	.....	.....
TAO	Roerig	1958	.....	X	.....
Tetracyn	Pfizer	1953	X	.....	.....
Chloromycetin palmitate ped	Parke, Davis	1951	X	.....	X
145 Anti-infectives, antibiotics, penicillin, and derivatives:					
Pentids	Squibb	1951	X	.....	
V-Cillin-K	Lilly	1957	X	.....	X
Penicillin G potassium	.....	1945	X	.....	.....
Compocillin-VK	Abbott	1957	.....	.....	X
Pen-Vee-K	Wyeth	1958	.....	.....	X
Syncillin	Bristol	1959	.....	X	X
Polycillin	....do	1963	.....	.....	.....
Pen-Vee	Wyeth	1955	.....	X	X
Bicillin	....do	1951	X	.....	X
Prostaphlin	Bristol	1962	X	.....	X
180 Anti-infectives, fungicides, systemic: Mycostatin.	Squibb	1954	X	.....	X
190 Anti-infestives sulfonamides, single:					
Gantrisin	Roche	1949	X	.....	X
Madribon	....do	1958	.....	X	X
Gantanol	....do	1961	.....	.....	X
Kynex	Lederle	1957	X	.....	X
205 Anti-inflammatory agents:					
Tandearil	Geigy	1961	.....	.....	X
Ananase	Rorer	1962	.....	.....	X
210 Antinauseants—motion sickness remedies:					
Tigan	Roche	1959	.....	X	X
Dramamine	Searle	1949	X	.....	X
Bonine	Pfizer	1953	X	.....	X
220 Antiobesity preparation amphetamine preparations: Desoxyn	Abbott	1944	X	.....	
225 Antiobesity preparation others:					
Tenuate	Merrell	1959	.....	.....	X
Preludin	Geigy	1956	.....	X	X
230 Ataraxics and tranquilizers:					
Librium	Roche	1960	.....	X	X
Equanil	Wyeth	1955	.....	X	X
Compazine	Smith Kline French	1956	.....	X	X
Valium	Roche	1963	.....	.....	.....
Thorazine	Smith Kline French	1954	X	.....	X
Stelazine	....do	1958	.....	.....	X
Miltown	Wallace	1955	.....	X	X
Meprobamate	.....	1955	.....	X	X
Atarax	Roerig	1956	.....	X	X
Mellaril	Sandoz	1959	.....	.....	X
Vistaril	Pfizer	1958	.....	X	X

200 leading drugs—Continued

(A) SINGLE CHEMICAL ENTITIES—Continued

	Product name	Manufacturer	Year introduced	USP XVII	NF XII	NND 1964
260	Cardiovascular preparation cardiotonics (Digitalis, etc.): Lanoxin	Burroughs Wellcome	1934	X		X
275	Cardiovascular preparation hypotensives—alkaloides (Rauwolfia, Veratrum):					
	Serpasil	Ciba	1953	X		X
	Reserpine			X		X
	Raudixin	Squibb	1953		X	X
280	Cardiovascular preparation vasodilators—coronary:					
	Nitroglycerin					
	Peritrate	Warner-Chilcott	1958			X
285	Cardiovascular preparation vasodilators—peripheral: Arlidin	Arlington-Funk	1955		X	X
350	Cough preparations: Robitussin	Robins	1949			
355	Nasal decongestants:					
	Neo-Synephrine nasal	Winthrop		X		
	Otrivin	Ciba	1959			X
	Sudafed	Burroughs Wellcome	1958			
	Tyzine	Pfizer	1954		X	X
370	Dermatological preparation antipruritics:					
	Termaril	Smith, Kline & French	1958			X
	Periactin	Merck, Sharp & Dohme	1961			
390	Dermatological preparation, other:					
	Synalar	Syntex	1961			
	Kenalog	Squibb	1958			X
	Cort-Dome	Dome	1955	X		X
	Cordran	Lilly	1961			
400	Diabetic therapy (hypoglycemic agents):					
	Orinase	Upjohn	1952	X		X
435	Diuretics, benzothiazides:					
	Diuril	Merck, Sharp & Dohme	1957		X	X
	HydroDiuril	do	1959	X		X
	Enduron	Abbott	1960			X
	Renese	Pfizer	1961			X
440	Diuretics, other: Hygroton	Geigy	1960			X
495	Gastrointestinal preparation, antidiarrheals and intestinal absorbents: Lomotil	Searle	1960			X
500	Gastrointestinal preparation, antispasmodics and anticholinergics: Pro-Bathine	do	1953	X		X
540	Gastrointestinal preparation, laxatives: Dulcolax	Geigy	1958			X
560	Hematinics plain: Feosol	Smith, Kline & French		X		
615	Hormones, corticoids plain:					
	Decadron	Merck Sharp & Dohme	1958		X	X
	Prednisone		1955	X		X
	Aristocort	Lederle	1958			X
	Celestone	Schering	1961		X	
	Medrol	Upjohn	1957		X	X
660	Hormones, estrogens: Premarin	Ayerst	1943			
670	Hormones progesterones: Provera	Upjohn	1959	X		X
710	Muscle relaxants general:					
	Soma	Wallace	1959			X
	Norflex	Riker	1959			X
730	Oxytocics: Ergotrate	Lilly	1935	X		
750	Psychostimulants:					
	Elavil	Merck Sharp & Dohme	1961			X
	Dexedrine	Smith Kline & French	1944	X		
	Tofranil	Geigy	1959		X	X
	Ritalin	Ciba	1956		X	X
760	Sedatives and hypnotics barbiturates:					
	Phenobarbital		1908	X		
	Seconal sodium	Lilly	1945	X		
	Nembutal	Abbott	1930	X		
	Butisol sodium	McNeil	1937		X	
770	Sedatives and hypnotics nonbarbiturates:					
	Doriden	Ciba	1955			X
	Placidyl	Abbott	1955		X	X
	Noctec	Squibb	1952	X		
	Noludar	Roche	1955		X	X
800	Thyroid preparations:					
	Thyroid	Unspecified		X		
	Proloid	Warner-Chilcott				
	Thyroid	Armour		X		
810	Thyroid therapy antithyroid preparations:					
	Cytomel	Smith Kline & French	1956	X		X
910	Vitamins					
	Nicotinic Acid				X	

200 leading drugs—Continued

(B) COMBINATION PRODUCTS

Product name	Manufacturer	Year introduced	USP XVII	NF XII	NND 1964
015 Analgesics, narcotics:					
Percodan	Endo	1951	.....	.....	.....
Phenaphen with codeine	Robins	1955	.....	.....	.....
020 Analgesics, nonnarcotic:					
Empirin compound with codeine	Burroughs Wellcome	.....	.....	.....	.....
Darvon compound 65	Lilly	1964	.....	.....	.....
Fiorinal	Sandoz	1952	.....	.....	.....
Equagesic	Wyeth	1960	.....	.....	.....
Darvon compound	Lilly	1957	.....	.....	.....
Coma compound	Wallace	1960	.....	.....	.....
Sinutab	Warner-Chilcott	1958	.....	.....	.....
Norgesic	Riker	1964	.....	.....	.....
Zactirin	Wyeth	1957	.....	.....	.....
100 Antihistamines: Co-Pyronil	Lilly	1952	.....	.....	.....
125 Anti-infectives, antibacterials and antiseptics, urinary: Azo Gantrisin	Roche	1956	.....	.....	.....
140 Anti-infectives, antibiotics, broad and medium spectrum:					
Mysteclin-F	Squibb	1960	.....	.....	.....
Panalba	Upjohn	1957	.....	.....	.....
Achrocidin	Lederle	1956	.....	.....	.....
Panalba KM	Upjohn	1958	.....	.....	.....
Declostatin	Lederle	1960	.....	.....	.....
Terrastatin	Pfizer	1961	.....	.....	.....
Signemycin	....do	1958	.....	.....	.....
160 Anti-infectives, antibiotics topical, other:					
Neosporin	Burroughs Wellcome	1954	.....	.....	.....
Cortisporin	....do	1955	.....	.....	.....
Mycolog	Squibb	1959	.....	.....	.....
Neo-Polycin	Pitman-Moore	1954	.....	.....	.....
195 Anti-infectives, sulfonamides multiple:					
Trisulfaminic	Dorsey	1957	.....	.....	.....
200 Anti-infectives, sulfonamides-antibiotics: Ilosone-Sulfa.	Lilly	1959	.....	.....	
205 Anti-inflammatory agents: Butazolidin alka.	Geigy	1958	.....	.....	
210 Antinauseants, motion sickness remedies:					
Antivert	Roerig	1957	.....	.....	
Bonadoxin	....do	1954	.....	.....	
220 Antiobesity preparations, amphetamine preparations:					
Eskatrol	Smith Kline French	1959	.....	.....	
Biphetamine	Strasenburgh	1961	.....	.....	
230 Ataraxics and tranquilizers: Deprol	Wallace	1958	.....	.....	
250 Bronchial dilators: Tedral	Warner-Chilcott	.....	.....	.....	
265 Cardiovascular preparations, hypotensives:					
Diupres	Merck Sharp Dohme	1959	.....	.....	
Hydropres	....do	1961	.....	.....	
SER-AP-ES	Ciba	1960	.....	.....	
340 Cold preparations antihistamines:					
Tuss-Ornade	Smith Kline French	1962	.....	.....	
Dimetapp	Robins	1960	.....	.....	
Triaminic	Dorsey	1956	.....	.....	
Tetrex-APC w/Bristamin	Bristol	1957	.....	.....	
Naldecon	....do	1959	.....	.....	
Novahistine	Pitman-Moore	1952	.....	.....	
Novahistine-DH	....do	1955	.....	.....	
Dimetane Expectorant-DC	Robins	1959	.....	.....	
345 Cold preparations general: Actifed	Burroughs Wellcome	1959	.....	.....	
350 Cough preparations:					
Phenergan expectorant w/codeine	Wyeth	.....	.....	.....	.....
Benylin expectorant	Parke, Davis	.....	.....	.....	.....
Phenergan expectorant	Wyeth	1963	.....	.....	.....
Ambenyl expectorant	Parke, Davis	1954	.....	.....	.....
Tussionex	Strasenburgh	1957	.....	.....	.....
Phenergan VC Expectorant w/codeine	Wyeth	1962	.....	.....	.....
Hycomine	Endo	1956	.....	.....	.....
Robitussin A-C	Robins	1954	.....	.....	.....
Hycodan	Endo	1948	.....	.....	.....
355 Nasal decongestants: Ornade	Smith Kline French	.....	.....	.....	.....
370 Dermatological preparations antipruritics: Vioform w/hydrocortisone.	Ciba	1956	.....	.....	.....
435 Diuretics, benzothiazides:					
Hydro Diuril-KA	Merck, Sharp & Dohme Division.	1960	.....	.....	.....
Esidrix-K	Ciba	1960	.....	.....	.....
Naturetin W K	Squibb	1960	.....	.....	.....

200 leading drugs—Continued
(B) COMBINATION PRODUCTS—Continued

Product name	Manufacturer	Year introduced	USP XVII	NF XII	NND 1964
450 Ear preparations: Auralgan	Ayerst				
470 Eye preparations (ophthalmic):					
Neo-Decadron	Merck Sharp & Dohme	1959			
Zincfrin	Alcon				
485 Gastrointestinal preparations antacids plain:					
Maalox	Rorer				
Mylanta	Stuart	1961			
495 Gastrointestinal preparations antidiarrheals and intestinal absorbents:					
Donnagel-PG	Robins	1960			
Paregoric			X		
500 Gastrointestinal preparations antispasmodics and anticholinergics:					
Donnatal	Robins				
Bentyl w/Phenobarbital	Merrell	1954			
505 Gastrointestinal preparations antispasmodics and anticholinergics combinations:					
Librax	Roche	1961			
Combid	Smith Kline French	1967			
565 Hematinics with vitamins: Trinsicon	Lilly	1953			
615 Hormones corticoids plain: Neo-Cortef	Upjohn	1954			
620 Hormones corticoids analgesic combinations: Decagesic	Merck Sharp Dohme	1960			
675 Hormones progesterones-estrogens combination:					
Enovid	Searle	1957			X
Ortho-Novum	Ortho	1963			X
Enovid-E	Searle	1964			
710 Muscle relaxants general: Robaxisal	Robins	1960			
750 Psychostimulants: Dexamyl	Smith Kline French	1950			
760 Sedatives and hypnotics barbiturates:					
Tuinal	Lilly				
Carbrital	Parke, Davis				

PROPOSED AMENDMENT OF SECTION 1861 (t)

The term "drugs" and the term "biologicals" include only such drugs and biologicals as are ordered or prescribed by attending physicians for the care and treatment of patients and which may lawfully be introduced into interstate commerce under the Federal Food, Drug, and Cosmetic Act.

The CHAIRMAN. Thank you very much, Dr. Smith.

Any questions?

Senator ANDERSON. In your statement you deal with this question of reasonable costs. How do you know that something isn't a valid drug? You mention the costs of a drug, the physician may be allowed to prescribe. This bill doesn't say it all, does it? It says if he does prescribe something the cost of that shall be reasonable. How do you twist it around?

Dr. SMITH. It is a question of interpretation, Senator.

Senator ANDERSON. Well, it is in the English language and it is fairly plain, isn't it?

Dr. SMITH. We believe that if this wording remains that an interpretation of the reasonable costs could be extended in several directions. One direction would mean there would be an unfortunate limitation of the drugs that are available.

Senator ANDERSON. Where did you find that in the bill? Reasonable costs of such services.

Dr. SMITH. As might be rendered.

Senator ANDERSON. Yes. They say he shall decide whether to operate on the man or give him gas.

Dr. SMITH. No, the concern that bothers us, Senator, as in other countries when there has been a question of costs arising there have been limitations, on the kind of services, the kind of products that could be made available.

Senator ANDERSON. Under language such as this?

Dr. SMITH. We think this is possible.

Senator ANDERSON. No, no. Has it happened under language such as this?

Dr. SMITH. This, I cannot say.

Senator ANDERSON. Don't you think you should be able to say it before you testify to that?

Dr. SMITH. I can only tell you what the experience has been, as I understand it and others understand it elsewhere. I do not know the exact wording of these, although I can say this is available from a number of sources ranging from World Medical Association records to elsewhere.

Senator ANDERSON. Could you submit some of those records showing they have eliminated drugs under language such as this?

Dr. SMITH. Well, we can attempt to get language that effects the distribution, the availability of drugs, and then if you would wish, sir, and try to relate that to the language as it reads here and to the fears that we hold in this kind of language.

Senator ANDERSON. I can't find where you can put that interpretation on it at all. It says, "shall be the reasonable costs of such services." It doesn't say they can distinguish between services. Let me give you a personal example. When I go into a hospital they make me take insulin from a nurse, I have been giving myself insulin for 25 years, I can do it reasonably well and to my satisfaction. When I go to a hospital they charge $2 to give me a shot and since I take four shots in a day, that is $8; because that looked to be high would you say they would say I couldn't have insulin any longer? Do you think that is possible?

Dr. SMITH. No——

Senator ANDERSON. I don't, either.

Dr. SMITH. I would say that there is a possibility that they might substitute, want to substitute something else for this.

Senator ANDERSON. Substitute what?

Dr. SMITH. Some of the oral preparations that are available today.

Senator ANDERSON. You mean they wouldn't have to find out whether I react properly to oral?

Dr. SMITH. No.

Senator ANDERSON. My doctor does.

Dr. SMITH. Yes.

Senator ANDERSON. Why would they not do that?

Dr. SMITH. That is what we are trying to do, guarantee the right of the physician to make a decision.

Senator ANDERSON. How can you suggest anything plainer than that? Can you suggest any language? Reasonable costs of such services, not some fanciful services.

Dr. SMITH. I think we have in our full statement.

Senator ANDERSON. You quoted a part of the House report. Would you mind if the rest of the House report went in?

Dr. SMITH. I am sorry, I didn't hear you.

Senator ANDERSON. You quoted a portion of the House report. Would you mind if the other paragraph went in?

Dr. SMITH. No.

Senator ANDERSON (reading):

> The appropriate basis of payments for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking consideration for more than a decade. Governing principles have been determined which have attained a large measure of agreement. It is the intent of the bill that in framing regulations full advantage shall be taken of experience of private agencies in order that rates of payment to hospitals may be both fair to the institution, to the contributors, or to the hospital insurance trust funds, and to other patients. In framing the regulations the Secretary and his staff shall consult with the organizations that have developed these principles as well as the associations of providers of prices.

That is what the House said was the purpose of this. You seem to think it is the purpose to cut off somebody's treatment. I can't find the language at all and if you can find it in the bill I wish you would submit it for the record at some time. This doesn't say it. This says just the reverse.

Dr. SMITH. We weren't implying that the bill intends this. We were expressing the fear that under this wording in this one particular sentence this cutoff could occur. We hope that the record will support your intent that there should be no interference in the physician-patient relationship.

Senator ANDERSON. And I find nothing in the bill that does that. Can you find it?

Dr. SMITH. Well, we think that this wording may raise this possibility in the future and that is why we are directing attention to it.

Senator ANDERSON. And this is all you find that does that.

Dr. KLUMPP. The other provision, 1861(t) interferes with the practice of medicine in that it prescribes a limited group of drugs that may be used under the provisions of this bill in the practice of medicine.

In other words, it says to the doctors the tools "that you use for the treatment of disease shall be only these tools and not the others."

In my opinion that is an interference with the practice of medicine.

Senator ANDERSON. You think that is bad?

Dr. KLUMPP. Yes, sir; very bad.

Senator ANDERSON. You would condemn the board of health of any State that did it, wouldn't you?

Dr. KLUMPP. I think that as a matter of basic principle Federal legislation has no business in interfering with the prerogatives of physicians in determining what those physicians shall be and what they shall use in the treatment of disease.

Senator ANDERSON. What is your home State, may I ask?

Dr. KLUMPP. New York State.

Senator ANDERSON. Well, let me just say this, in your statement you do get into this question of the requirements that the drug be included in a compendium of approved drugs, to be approved by hospital committees to be paid for as made available.

Would it set up unworkable barriers to physicians, would you say medical care for Blue Cross patients, is inferior, in Illinois or other States where drugs listed in the U.S. Pharmacopoeia are paid for and only those?

Dr. KLUMPP. Well, Mr. Senator, I think that any provision in any law that ties the hands of physicians in what they may use is wrong, as a basic principle.

Senator ANDERSON. I don't know what this list is that was submitted, maybe Dr. Smith can explain what this list is here. I am very interested in it. What is the purpose of this list that you submitted? This long list of 200 leading drugs.

Dr. SMITH. These are the 200 drugs most frequently prescribed in the United States by physicians in 1964. The purpose of submitting it was to indicate how many drugs would not be included under the present wording of the bill.

Senator ANDERSON. And it is your testimony then, that these drugs that are listed on this list are excluded under the bill?

Dr. SMITH. Ninety-one of them are.

Senator ANDERSON. Well, how do we know which ones then? You have an easy figure, 91, you might just as well have said 150. How many are excluded? I look at this one in your statement. I don't know what the first word means, after Ataraxics, I have had doctors prescribe for me Equanil, I took some of it the other morning with the American Medical Association testimony where they insisted that no doctors had anything to do with the framing of the King-Anderson bill or the Javits bill which was completely dishonest. Then there is Miltown, Meprobamate.

Do the doctors that give me Equanil violate the law?

Dr. SMITH. I am sorry. I cannot hear you.

Senator ANDERSON. Do the doctors that give me Equanil, do they violate the law when they give me Equanil?

Dr. SMITH. No.

Senator ANDERSON. Would they if this bill passed? Is it your testimony that the heart specialist couldn't prescribe Equanil for me if he wished and get paid for it?

Dr. SMITH. He could now simply because Miltown is going to be in the National Formulary for 1965 edition but if it were not in the 1965 edition or in the U.S. Pharmacopoeia or not recognized by a therapeutic formulary committee in a hospital, it would not be covered.

Senator ANDERSON. But it is. If Columbus had not discovered America he would n't have been here.

Dr. SMITH. At the moment Miltown is.

Senator ANDERSON. Yes, I see Serpasil and Peritrate, all of them are sitting on the dresser in my home.

Are these to be not prescribed, is that your testimony?

Dr. SMITH. We don't know what would be in the compendia by the time the bill is enacted. We can only speak about what is there now.

Senator ANDERSON. I say Illinois struggles along on it.

Now, there is a State called Virginia, in Virginia only drugs listed in the U.S. Pharmacopoeia and National Formulary new and nonofficial drugs are covered by Blue Cross.

Would you say the practice of medicine in Virginia is poor?

Dr. SMITH. I have high respect for the practice of medicine in Virginia.

Senator ANDERSON. Well, they are following what would be in the bill.

Is that so bad then?

Dr. KLUMPP. Mr. Chairman, in my opinion, I would not say that the practice of medicine in Virginia is poor. I happen to also be a resident of Charlottesville, Va. The practice of medicine there is at a very high level. But with respect to this specific provision, there are imposed on the physicians of Virginia limitations which I am sure the physicians of Virginia object to.

Senator ANDERSON. When did you go and ask that they be removed officially? When did the medical association take any stand on this officially?

Dr. KLUMPP. I can't tell you specifically.

Senator ANDERSON. Have you ever participated in a movement to get that restriction removed?

Dr. KLUMPP. I think so.

Senator ANDERSON. In Virginia?

Dr. KLUMPP. I don't know about Virginia.

Senator ANDERSON. I said have you?

Dr. KLUMPP. Pardon me.

Senator ANDERSON. Have you as an individual ever tried to get this removed in Virginia?

Dr. KLUMPP. No, sir.

Senator ANDERSON. No.

Now, the State of Louisiana; is the State of Louisiana backward? Only those drugs in the Pharmacopoeia and National Formulary are covered.

Dr. KLUMPP. Mr. Chairman, I would like to ask a broad question.

Senator ANDERSON. Surely because these States can live with the same language that is in this bill and you say it is going to limit physicians.

Dr. KLUMPP. They are not living insofar as making available to the physicians all the tools that they want to use and sometimes need to use.

Senator ANDERSON. Are you limited in the State of Virginia?

Dr. KLUMPP. I thought I mentioned I am a resident of New York. I have a farm in Charlottesville.

Senator ANDERSON. Charlottesville. Well, if you did practice in Charlottesville, would you be limited because of this?

Dr. KLUMPP. Yes, sir; very definitely.

Senator ANDERSON. Isn't it strange that doctors of Virginia don't seem to feel so bad about it?

Dr. KLUMPP. I am not sure that that is so.

Senator ANDERSON. All right.

You say, Dr. Smith, that restrictions such as are in the bill have no demonstrable place in good medicine.

Are you ready to acknowledge the authority of the Joint Committee of Accreditation of Hospitals which requires that the hospitals accreditation meet the standards cited by USP or the National Formulary. It doesn't do that?

Dr. SMITH. No.

Senator ANDERSON. Then the Joint Commission on Accreditation of Hospitals doesn't require for a hospital's accreditation that its drugs meet the standards established by USP and NFP for drugs?

Mr. STETLER. It is one of the things they look at when they investigate a hospital. It is not a requirement to accreditation.

Senator ANDERSON. It isn't in the standards?

Mr. STETLER. It is not a requirement for accreditation.

Senator ANDERSON. This is put out by the American Hospital Association. You dispute it then?

Mr. STETLER. I would like to see the wording. I am confident it is not a requirement. It is one of the things they check. It is one of the things they recommend and that they look for but accreditation per se is not based or denied on that point.

Senator ANDERSON. I don't suppose accreditation is based on one exclusive point but one of the standards they use is whether or not these drugs meet these standards and we put it in the bill and you say that is bad.

(The following letter, relating to this question and a pertinent page from the standard survey report of the Joint Commission on Accreditation of Hospitals, were subsequently submitted by Senator Anderson for the record.)

KENNETH B. BABCOCK, M.D., HOSPITAL CONSULTANT,
Fort Lauderdale, Fla., May 14, 1965.

Hon. CLINTON ANDERSON,
U.S. Senate, Washington, D.C.

DEAR SENATOR ANDERSON: I've been asked to write to you concerning one of the rules of the Joint Commission on Accreditation of Hospitals. It concerns the use of drugs.

As identification, I am the former director of the commission and am still, at present, an active consultant to them.

The commission specifically, when it surveys hospitals, asks the question, "Do you use only drugs found in the United States Pharmacopoeia, the National Formulary, and New and Non-Official Drugs?" If the answer is "No" the hospital is downgraded in the marking of the examiner.

Of itself this would not necessarily mean nonaccreditation. But, if there were several other discrepancies found with it, then the hospital might well lose its accreditation. Let me put it this way. We grade or mark very similar to high schools and colleges. One mistake does not flunk a student but it does lower his grade. Enough mistakes could mean a nonpassing grade. We definitely feel the item in question is an important one in our overall examination.

Accompanying this letter is a blank copy of the grading form used by our surveyors. I have marked the area in question.

Mr. Kenneth Williamson of the Washington Bureau of the American Hospital Association asked me to write this information to you.

Sincerely,

KENNETH B. BABCOCK, *Consultant.*

PHARMACY AND DRUG CONTROL

1. The location of the pharmacy or drug room is suitable. Yes_____ No_____
2. It is adequately supplied with official preparations. Yes_____ No_____
3. There is evidence of control in the operations of the drug room. Yes_____ No_____
4. If there is a pharmacy there is evidence of control in the absence of the pharmacist.
   Yes_____ No_____.
5. Only U.S.P., N.F., or N.N.D. quality preparations are used. Yes_____ No_____
6. Narcotics, hypnotics, and alcohol are handled under properly controlled conditions.
   Yes_____ No_____
   Floor supplies of these drugs are properly controlled. Yes_____ No_____
7. There are policies established and enforced to control the administration of dangerous and toxic drugs.
   Yes_____ No_____
   N. P. F._____

Dr. KLUMPP. Mr. Chairman, there is a more fundamental objection, it seems to me. Obviously the intent of 1861(t) is to control costs, and we recognize that good housekeeping on the part of the Federal Government makes it desirable to do that. But to try to control costs by limiting the physician in what—in the tools that he may use is the wrong way to do it.

Senator ANDERSON. Do you have faith in Blue Cross as an organization?

Dr. KLUMPP. Pardon me, sir?

Senator ANDERSON. Do you have faith in Blue Cross as an organization?

Dr. KLUMPP. I am a member of Blue Cross.

Senator ANDERSON. Does Blue Cross allow payment of drugs on this list in Illinois?

Mr. STETLER. I think the answer to that, Senator, is that it varies from State to State. They have different rules and requirements in different States.

Senator ANDERSON. Well, in the State of Illinois except Winnebago County, according to this Blue Cross guide which may not be authoritative according to the American Medical Association, it provides for all drugs, biologicals, and solutions except blood plasma and other human blood derivatives which are listed in the United States Pharmacopoeia or other official formularies at the time of admission.

You say that is a bad provision?

Mr. STETLER. I believe, and I am not absolutely sure, but I believe that in operation—reimbursement is made under Blue Cross in Illinois for combination products which would not be included in that definition.

Senator ANDERSON. Now, in Louisiana they have much the same thing and it says cost of all drugs, medicines, and serums except blood and blood plasma listed in the United States Pharmacopoeia and National Formulary specially ordered by the attending physician and furnished by the hospital.

You think that is a bad provision?

Mr. STETLER. I think if in actual operation they apply that very strictly then they do limit their reimbursement to only about 50 percent of the drugs that are normally prescribed. I have a feeling, however, that they do not apply the letter of that requirement.

Senator ANDERSON. You don't think Blue Cross lives up to what it says?

Mr. STETLER. I think Blue Cross in operation does reimburse for combination drugs and they would not be accommodated by that definition.

Senator ANDERSON. If Blue Cross did testify that they live up to this, would you withdraw your objection to this section of the bill?

Mr. STETLER. No, sir.

Senator WILLIAMS. Doctor, as I understand your testimony in connection with this list of 200 drugs, assuming this bill is passed there would still be nothing in the law that would prohibit you from prescribing any of those drugs but it would merely mean that on the 91 which were not included the patient could not be paid under this bill.

Dr. SMITH. Yes.

Senator WILLIAMS. The patient would have to pay for it on his own on the side or the physician would not be allowed to prescribe it?

Dr. SMITH. That is right.

Senator WILLIAMS. That is my understanding.

Dr. SMITH. Yes.

Senator WILLIAMS. In connection with the term "drugs," an earlier witness has suggested this amendment and I am just going to read it to you and see if you would care to comment on this proposed amendment. It is not mine but suggested earlier.

The term "drugs" and the term "biologicals" include only such drugs and biologicals as are ordered or prescribed by attending physicians for the care and treatment of patients and which may lawfully be introduced into interstate commerce under the Federal Food, Drug, and Cosmetics Act.

Are you familiar with that amendment which was suggested earlier?

Dr. SMITH. No, I am not, Senator.

Senator WILLIAMS. Would you care to comment on it?

Dr. SMITH. As I heard it read it would sound to me as if it would provide for freedom of choice for the physician according to the needs of the patient.

Senator WILLIAMS. Well, the amendment has been in the record before and I will see that it is in.

Would you check it and would you care to give us your comments just for the benefit of the committee?

Dr. SMITH. Yes.

Senator WILLIAMS. Thank you.

Dr. SMITH. I might say this, as we understand it here we certainly would support this kind of an approach. We wouldn't want any misunderstanding about that.

Senator CURTIS. Do we have need to clarify two problems here, in deciding what some bureau might at some future date interpret to mean reasonable costs? One problem is if the physician has absolute freedom to prescribe the drug that he thinks is best, that that particular drug be furnished without excessive profits. You would agree that would be a satisfactory objective?

Dr. SMITH. Yes.

Senator CURTIS. Now, on the other hand, if the interpretation would ever develop where there is a drug that does the patient some good, or it does most patients, its cost is rather much, but there may be a rare drug or a new drug or a drug that is very expensive to manufacture available that under the most favorable circumstances would be exceedingly expensive, you do not want the requirement for reasonableness of cost to prevent the physician from using that very expensive drug if that is what is best for the patient, is that right?

Dr. SMITH. This is so, Senator. We feel that the physician should be educated to use what is best and certainly locally he can determine what is most reasonable in costs to meet the needs of the patient in the program. But if there is a need existing for the patient then the physician should be able to provide it. It is true as was pointed out earlier, that someone could pay for it even though it is not included in the list but our feeling has been from the beginning and still is this is an arbitrary decision to make. It would divide people who are 65 and over into two classes of citizens, those under medicare and those who aren't and it would also vary greatly from one area of the country to another because of local practices.

Senator CURTIS. I have in my files in my office a most interesting case relating to a World War II veteran, in a veterans' hospital. He was suffering from an ailment and his family had been advised he was going to die, it was just a matter of time. A new drug appeared. The physicians in the veterans' hospital were aware of this discovery and of its value, and the probability that it would bring recovery. But under the regulations of the Veterans' Administration they could not prescribe it, and in this particular case they informed the veteran and his family even though they were people of modest means, they said secure the drug. It rescued this young man from death. He is an active farmer today, and I will say this for the Veterans' Administration retroactively they supported a legislative proposal of mine that went back and made it possible to reimburse this veteran for this very expensive drug.

Does that somewhat illustrate what you have in mind when you say you have to be tied to a published list?

Dr. SMITH. Exactly, Senator

Dr. KLUMPP. Exactly.

Dr. SMITH. An excellent illustration.

Senator CURTIS. Now, are the words in here, do you have 161(t) before you? It says the term "drugs" and the drugs, biologicals except for the purpose of subsection (m) (5) of this section included only such drugs and biologicals respectively as are included in the U.S. Pharmacopoeia or the National Formulary or in new or accepted dental remedies—in new drugs or accepted dental remedies except any drugs and biologicals unfavorably evaluated there, or as are approved by the pharmacy and drug therapeutics committee or equivalent committee of the medical staff of the hospital furnishing the drug.

Do you feel you are given adequate leeway, that the doctor is given adequate leeway in there by the words "new drugs or accepted dental remedies"?

Dr. SMITH. No.

Senator CURTIS. Why not?

Dr. SMITH. Because they are not all inclusive.

Senator CURTIS. I see.

Dr. SMITH. As explained in the various pages here, there are limitations imposed on the admission of drugs to these various compendia.

Furthermore, only about, well, one-sixth of hospitals have active formulary or therapeutic committees.

Senator CURTIS. Under this language, now it is pretty hazy, does the new drug have to be one approved by the hospital committee?

Dr. SMITH. Well, new drugs as of what?

Senator CURTIS. What is that?

Dr. SMITH. The "New Drugs" you are referring to is a book that is coming out from the Council on Drugs of the AMA.

Senator CURTIS. I have no idea.

Dr. SMITH. It is a book.

Senator CURTIS. That is a book.

Dr. SMITH. Yes.

Senator CURTIS. "New Drugs" or "Accepted Dental Remedies."

Dr. SMITH. Yes, sir; these are books.

Senator CURTIS. I will ask you this and I don't want to drag this on for a long time, we have other witnesses here.

Was there ever a time in the history of medicine, when unusual medicines were available to the extent they are now, way ahead of any publication list even though it has been revised recently?

Dr. SMITH. Yes; many examples.

Senator CURTIS. That is one of the situations that we must consider.

Dr. SMITH. Yes.

Dr. KLUMPP. Mr. Senator, may I illustrate that?

New drugs and new discoveries are emerging from our laboratories constantly. Let us assume, for instance, that a new drug that could take care of a coronary heart attack were released and made available. It takes a long time for these compendia to go through the procedure of having them included. It takes a time for hospital formulary committees, where they exist, and we have shown that they exist in only one out of seven hospitals.

In the meantime, people are dying because the hospitals and the doctors are unwilling to use these new preparations because they are not reimbursed for them, and this is the issue here. But more important than that is this basic issue that you should not limit the practice of medicine, the tools available to the physicians, in order to cut costs.

Senator CURTIS. In other words, to put it in a nutshell it amounts to this: If reasonable costs have any chance of affecting the selection of the drug then it is bad.

Dr. KLUMPP. Yes, sir.

Senator CURTIS. If it is solely within the framework that whatever is selected the system isn't gaged in price, then it is all right, is that your position?

Dr. KLUMPP. Yes, sir.

Senator CURTIS. That is all.

Senator ANDERSON. Can I ask one more question.

You referred again to the question of Senator Curtis that one in seven hospitals have these committees. Will you state for the record whether a majority of patients in the hospitals are in hospitals having these committees on new drugs, and so forth?

Aren't the overwhelming proportion of hospital patients in hospitals with a functioning organization of some kind to approve drugs for use in a hospital.

Dr. SMITH. I can't give you an exact figure, Senator, I think we can give you that information.

Senator ANDERSON. I wish you would supply it because the record we have shows an overwhelming majority of them are that type patient, not one in seven.

Dr. SMITH. I think that it is contrary to that, but we will get the information for you, Senator.

Senator ANDERSON. Thank you.

(The information referred to follows:)

PHARMACEUTICAL MANUFACTURERS ASSOCIATION,
Washington, D.C., May 17, 1965.

HON. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: During our appearance before your committee May 13, certain questions were raised concerning which we promised to supply additional information.

The first dealt with the accuracy of Senator Anderson's statement that pharmacy and therapeutics committees are extant in the majority of the larger hospitals and that the majority of beneficiaries under H.R. 6675 could expect to be hospitalized in such institutions.

This statement is illustrative of the problem our testimony attempts to emphasize and remedy. It is literally true that about 50 percent of the larger hospitals, those with 100 or more beds, have drug committees that meet once a year or more. In those hospitals, that is, about half of the larger hospitals, the drug committees could broaden the assortment of drugs to be provided under section 1861(t) to give the elderly the same drugs that are available to other patients. This simply means the elderly in larger hospitals would have something on the order of a 50–50 chance of getting all the drugs they deserve.

A much lower percentage of hospitals with fewer than 100 beds have therapeutic committees.

It is important in this connection to recognize that the smaller hospital is not, as some might contend, of minor importance in the Nation's health care. Of the 7,004 hospitals in the United States, a 1964 American Hospital Association survey shows that 4,080 have fewer than 100 beds each. Those smaller hospitals had a total of 6,758,644 admissions in 1963, the AHA survey shows.

We submit that institutions that numerous, offering that many beds, caring for so many millions of illnesses each year, are not to be passed off as unimportant. The most current information we have discovered concerning the availability of pharmacy and therapeutics committees in these smaller institutions is found in a report on a Government-financed study conducted by the American Society of Hospital Pharmacists, published last year. It states: "Among the short-term hospitals with less than 100 beds the percentage having committees decreases sharply from 37 percent in hospitals with 50 to 99 beds to 4 percent in hospitals with less than 25 beds."

Thus it is patently clear that in the vast majority of smaller hospitals, the drugs available under section 1861(t) will be limited to those listed in the cited compendiums since no therapeutic committee exists. In effect, then, thousands of older patients hospitalized in community and rural hospitals near their homes are going to be penalized as regards drugs to be covered, on the grounds they happen to live away from the great metropolitan centers.

Senator Anderson's second comment on which we would offer our further view has to do with restrictions in certain State Blue Cross contracts that are similar in wording to the present section 1861(t). We believe it is true that such restrictions do appear in some Blue Cross contracts; and, especially in light of the facts presented in the first part of this letter, it is reasonable to ask why, if this kind of language is troublesome, few serious objections have been raised to them.

We believe the reason lies in the economic, rather than medical, basis for such contract limitations. In presenting bills for payment, hospital contractees under Blue Cross do not normally itemize the drugs dispensed or administered; they merely indicate the pharmacy charges for each payment. Indeed, it is our understanding from conversations with Blue Cross representatives that only when an exceptionally high pharmacy bill is presented, and there is a subsequent inquiry to learn the basis for the bill, does Blue Cross normally learn what drugs are involved in a given case.

Obviously then, Blue Cross is not often in a position to know whether drugs it pays for are restricted to the ones listed in the various compendiums. Bearing in mind that in practice the contract language is intended largely as an economic tool, it is clear the plans do not really care, if the cost is within customary bounds and all other factors remain equal.

We understand further that when Blue Cross does find an uncommonly high pharmacy charge for a given patient, it seeks the advice of the hospital drug committee (if there is one) before refusing to render payment, in order to learn the medical justification for the therapy.

In any event, it is apparent that Blue Cross hospitals regularly administer, and Blue Cross regularly pays for, drugs that are not in the compendiums. We think this fact lends further support to our contention that restrictive language such as is in section 1861(t) is impractical and will, if Blue Cross is any example, not be observed.

The only other comment I would like to add for the record is to restate the support of the Pharmaceutical Manufacturers Association for the language read by Senator Williams as a substitute for the present wording of section 1861(t).

Mr. Chairman, we know this bill cannot meet every circumstance of every aged patient. But as we have tried to show in our testimony and here, there is no need for it to fail to meet the reasonable needs of many thousands of people, as it now does, for lack of a recognition of the facts of hospital life as they are. We sincerely hope your committee will make a reasonable modification of its language along the lines we have suggested.

We shall, of course, be ready to comment further if that is desired.

Cordially,

AUSTIN SMITH, M.D.

Dr. KLUMPP. But, Mr. Senator, the principle here, what you are propounding, it seems to me, is that it is all right for the majority but those poor devils who happen to be in these few hospitals or in hospitals that are not covered by formularies we aren't worried about them. In medicine we are worried about every single patient whether he is in a large hospital, with a large population that has a formulary committee, we are worried about the ones who are in the smaller hospitals that don't have formulary committees just as much. Life is too precious to deal with majority votes.

Senator ANDERSON. Well, I am sure we are all agreeable with that but when you can't get to them and you do have a majority that can be served, why not serve them? Why refuse to serve them? Why recognize the situation? You are the ones bringing out the figure that only one in seven has such a committee. I say the majority of people in hospitals are served by such a committee and I would be happy to see you introduce evidence to contradict that.

Dr. KLUMPP. But we are concerned with the minority as well as the majority.

Senator ANDERSON. Well, I have read some statements from the American Medical Association about the need for health service that would not agree with that conclusion.

You are talking about people who are poor and the American Medical Association has been saying for a long time no such thing exists.

The CHAIRMAN. Any further questions?

Senator Dirksen?

Senator DIRKSEN. Mr. Chairman, I would just like to know what the fuss is all about. I am sorry, I was before another committee that I couldn't get here. But for a matter of about 3 years or more the so-called Kefauver committee went into this drug business at great length. I was a member of the committee, and I guess I attended nearly every hearing we ever had. I finally emerged as the whipping boy because I had a few kind things to say about the pharmaceutical industry and they thought I was something of an ogre at the time. There was so much testimony presented that certainly didn't stand up in the light of day, that I thought they ought to have a fair shake in an open forum. I had no timidity about standing up for what I felt was a great industry that has done such a job for the American people.

There isn't anything comparable anywhere in the world, and I guess our thanks is that some of these foreign countries swipe your patents today, and some of them had to be indicted for it.

But whatever the record shows, Mr. Smith, I just want to say, after going through 3 years of hearings and then having to go through this so-called monopoly business with respect to Latin America—where we finally got those subpenas quashed and they should be quashed—I just want to salute the drug industry for the great job they have done, and

I don't believe you have ever asked for too much when you have come before any committee where I ever sat.

And I just want to assure you if you have amendatory language for this bill, it is going to receive considered attention when we come up to the markup phase.

Dr. KLUMPP. Thank you very much.

Senator DIRKSEN. That is all, Mr. Chairman.

The CHAIRMAN. Thank you very much, Dr. Smith.

The Chair announces that Mr. Howard W. Habermeyer, Chairman of the Railroad Retirement Board and Mr. Lester P. Schoene, representing the Railway Labor Executives Association, who were scheduled to testify today have submitted written statements in lieu of appearing. Their statements will be placed in the record at this time.

(The statements referred to follow:)

STATEMENT OF HOWARD W. HABERMEYER, CHAIRMAN, RAILROAD RETIREMENT BOARD

Mr. Chairman and members of the committee, my name is Howard W. Habermeyer, and I am Chairman of the Railroad Retirement Board. I have been associated with the Board since May 11, 1936, and I have been Chairman of the Board since November 26, 1956.

I am filing this statement in behalf of the Board in support of Senator Douglas' amendments No. 178 to H.R. 6675. These amendments would restore to the Railroad Retirement Board the jurisdiction provided for it in H.R. 1 and earlier bills relating to hospital insurance benefits for railroad employees. Unless the amendments are adopted, a social insurance program for railroad employees would be administered, for the first time, as a part of the social security program.

As you know, the Railroad Retirement Board administers an extensive social insurance program for people in the railroad industry. This program began in the middle thirties and in fact its inception antedates the social security program. The railroad retirement, disability, and survivors benefit program are similar to the OASDI program. Railroad service credits provide the basis for benefits and such service credits are, in general, excluded from the operation of the OASDI program. It is important to note that under H.R. 6675, as well as under Senator Douglas' amendments No. 178, the right to hospital insurance benefits of railroad employees, their dependents and survivors, is contingent upon the eligibility of such persons for benefits under the Railroad Retirement Act as determined by the Railroad Retirement Board.

Under the law now in effect, there is considerable coordination between the railroad retirement and the social security systems which is implemented in the administration of the two programs. For example, monthly survivor benefits are payable only under one or the other of the two systems based on combined credits. Where the employees has less than 10 years of railroad service credits at his retirement or death, his railroad service credits are treated for benefit purposes as social security credits. Further, under the social security minimum guarantee provision contained in the Railroad Retirement Act, monthly benefits can be not less than 110 percent of the amount, or the additional amount, that would be payable under the Social Security Act if the employee's railroad service had been employment subject to the Social Security Act. Moreover, there is by law a provision for financial interchange between the two systems which assures that the social security system would neither gain nor lose from the separate existence of the railroad retirement system.

Since 1961, when administration supported efforts to obtain a hospital benefits program began, the principal bills to establish the program, except H.R. 6675, have provided for Board jurisdiction over hospital insurance benefits for railroad retirement beneficiaries. Provisions for the Board's jurisdiction of the program as it relates to railroad retirement beneficiaries were included in H.R. 4222 and S. 909 in 1961, in H.R. 3920 and S. 880 in 1963 and in the bill H.R. 11865 as passed by the Senate on September 3, 1964. The bill H.R. 1, introduced in this session, which was succeeded by H.R. 6675, also included such provisions as does

the bill S. 1. Both the present and past administrations have favored jurisdiction of the Board over the hospital benefits program as it relates to railroad people, and the Department of Health, Education, and Welfare has always been fully in accord with this. Just recently, the Department of Health, Education, and Welfare informed me that it has no objection to Senator Douglas' amendment No. 178. As stated by Secretary Celebrezze in his testimony in support of H.R. 3920, 88th Congress, 1st session, and H.R. 11865, 88th Congress, 2d session:

"As in the case of other benefits under the social security system, overall responsibility for administration of the hospital and related benefits would rest with the Secretary of Health, Education, and Welfare. Similar responsibility for railroad retirement annuitants rests with the Railroad Retirement Board. Agreements by hospitals and other providers with the Secretary would be made on behalf of both the Secretary and the Board."

In contemplation of the Board's jurisdiction over the hospital issurance program for railroad employees, there have been discussions between the Board and the Social Security Administration for coordination between these two agencies in the administration of this program. As a consequence, agreements have already been reached which would provide for a close coordination and would effect an efficient administration of the program.

The American Hospital Association at one time objected to having to deal with two agencies. When informed, however, of the agreement between the Board and the Social Security Administration that arrangements with hospitals and other providers of services would be made only by the Social Security Administration but on behalf of both agencies, the hospital association formally declared that it no longer had any objection to the program on this basis.

Senator Douglas' amendments No. 178 expressly require that the Board and Secretary of Health, Education, and Welfare jointly develop procedures to minimize duplications of requests for payments of service and to assign administrative functions between them so as to promote the greatest facility, efficiency, and consistency of administration of the two programs; and the two agencies are in agreement that this can and will be done.

These amendments also expressly provide that agreements entered into by the Secretary with hospitals shall be entered into on behalf of both the Secretary and the Board. Except for identification of the patient as a railroad beneficiary the ordinary hospital or other facility would hardly be aware that the hospital insurance program for railroad employees is administered by the Railroad Retirement Board.

In view of these circumstances, it is logical and reasonable to restore the provisions for jurisdiction of the Board over the hospital insurance program as it relates to railroad people. It is a firmly established longstanding policy of the Congress for the Board to have jurisdiction over social insurance programs for railroad people and the Board has always administered such programs. There is no justification for a departure now from this policy and principle as to the hospital insurance program for the aged.

Senator Douglas' amendments No. 178 restoring jurisdiction in the Railroad Retirement Board for the hospital insurance program for railroad employees would, according to actuarial estimates, cost the railroad retirement system about $6,700,000 a year. This would result from the fact that railroad employers and employees would be paying the cost for the hospital insurance benefits on the present railroad retirement tax base of roughly $5,400 a year instead of on a tax base equivalent to the newly proposed social security tax base of $5,600 a year beginning in 1966 and $6,600 beginning with 1971. This loss, however, will be eliminated as soon as the railroad retirement tax base is increased to an amount equivalent to the newly proposed social security tax base. There is ample reason to believe that this loss would only be temporary because, except for a single relatively short period in the early 1950's the railroad retirement tax base has always equaled or exceeded the social security tax base. Therefore, as soon as the railroad retirement tax base is increased to the equivalent of the social security tax base (as will most likely be the case) there would no longer be any loss to the railroad retirement system by reason of the jurisdiction in the Railroad Retirement Board over the hospital insurance program as it relates to railroad employees.

I hope, therefore, that the committee will act favorably on Senator Douglas' amendments No. 178.

STATEMENT OF LESTER P. SCHOENE, ATTORNEY, REPRESENTING THE RAILWAY LABOR EXECUTIVES' ASSOCIATION, IN FAVOR OF SENATOR DOUGLAS' AMENDMENTS NO. 178 TO H.R. 6675

Mr. Chairman and members of the committee, my name is Lester P. Schoene. I am a lawyer engaged in the general practice of law with offices at 1625 K Street NW., Washington, D.C. This statement is presented on behalf of and as counsel for the Railway Labor Executives Association, whom I have represented in these matters for more than 20 years.

The Railway Labor Executives Association consists of the chief executives of some 22 labor organizations. These organizations constitute substantially all the standard labor organizations in the country. The following is a list of the organizations whose chief executives are affiliated with the association:

American Railways Supervisors' Association.
American Train Dispatchers' Association.
Brotherhood of Locomotive Firemen & Enginemen.
Brotherhood of Maintenance-of-Way Employees.
Brotherhood of Railroad Signalmen.
Brotherhood of Railroad Trainmen.
Brotherhood of Railway Carmen of America.
Brotherhood of Railway & Steamship Clerks, Freight Handlers, Express & Station Employees.
Brotherhood of Sleeping Car Porters.
Hotel & Restaurant Employees & Bartenders International Union.
International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers & Helpers.
International Brotherhood of Electrical Workers.
International Brotherhood of Firemen & Oilers.
International Organization Masters, Mates & Pilots of America.
National Marine Engineers' Beneficial Association.
Order of Railway Conductors & Brakemen.
Railroad Yardmasters of America.
Railway Employees' Department, AFL–CIO.
Seafarers' International Union of North America.
Sheet Metal Workers' International Association.
Switchmen's Union of North America.
Transportation-Communication Employees' Union.

It will be noted that this list includes the Railway Employees' Department, AFL–CIO, which is, itself, a federation of the shop craft organizations.

Collectively, these organizations represent the great bulk of organized railroad employees in the country.

Our association has for many years maintained a standing committee on railroad retirement and railroad unemployment insurance matters, and this committee makes recommendations, from time to time, to the association for legislative actions with regard to the railroad retirement and railroad unemployment insurance systems. Pursuant to this practice, this standing committee had recommended to the association, some time before 1961, that the association join forces with other groups in the country to sponsor the enactment by the Congress of a program of hospital and medical insurance benefits for elderly or retired employees with the understanding that the Railroad Retirement Board would administer such a program, insofar as it relates to railroad employees.

The association has adopted the committee's recommendation and, pursuant thereto, has sponsored jointly with other groups the bill containing the hospital and medical insurance program now under consideration by your committee.

The Railroad Retirement Board, which administers the Railroad Retirement Act and the Railroad Unemployment Insurance Act for the benefit of railroad employees, their dependents, and survivors, has advised the association that representatives of the Board and of the Department of Health, Education, and Welfare agreed that the bill for hospital and medical insurance benefits would contain provisions for the administration of such benefits for railroad employees by the Railroad Retirement Board. I, myself, in the capacity of counsel for the association, cooperated with the counsel of the Railroad Retirement Board in the drafting of such provisions, which were incorporated in the bills, H.R. 4222 and S. 909, both introduced February 13, 1961.

During the hearings before the Ways and Means Committee of the House on the bill, the Secretary of Health, Education, and Welfare (Mr. Ribicoff) stated the following in regard to such provisions:

"The bill covers railroad retirement beneficiaries as well as OASI beneficiaries. It provides that agreements between the Secretary and providers of services or their agents will be entered into also on behalf of the Railroad Retirement Board. Coverage for railroad beneficiaries would include services secured in railroad hospitals which, otherwise, may not be participating under the program, and services in Canadian hospitals, which for OASI beneficiaries are excluded from the program. In the case of individuals who may be entitled to monthly benefits under both programs the limitations on number of days, units of care, and the deductible provisions would be applied as if the individuals were covered under a single program.

"The administration of present law requires close coordination between RRB and BOASI in recordkeeping and claims processes. There has been continuing and extensive experience between these agencies in the kinds of coordination that would be required under a health benefits program. Where individuals are entitled under both programs, agreement would be reached on which organization will issue the identification card. Railroad hospitals and Canadian hospitals would send their requests for verification of eligibility direct to the RRB. Hospitals in the United States, other than railroad hospitals which do not have an agreement with the Secretary, would accept either card and a common procedure would be established for requesting verification of eligibility. The RRB could be linked with the OASI wire communications system. Bills could be paid under uniform policies and procedures, and the trust funds of the two programs could be adjusted periodically through the financial interchange provisions of the act." [1]

The same provisions for administration by the Railroad Retirement Board of hospital insurance benefits for railroad employees were included in the bills, H.R. 3920 and S. 880, both introduced on February 21, 1963, and the bill, H.R. 11865, which was passed by the Senate on September 3, 1964. In his testimony before the House Committee on Ways and Means on H.R. 3920, the Secretary of Health, Education, and Welfare (Mr. Celebrezze) stated as follows:

"As in the case of other benefits under the social security system, overall responsibility for administration of the hospital and related benefits would rest with the Secretary of Health, Education, and Welfare. Similar responsibility for railroad retirement annuitant rests with the Railroad Retirement Board. Agreements by hospitals and other providers with the Secretary would be made on behalf of both the Secretary and the Board." [2]

The Secretary made the same statement in his testimony before this committee on H.R. 11854.[3]

The same provision for the administration by the Railroad Retirement Board of hospital insurance benefits for railroad employees was incorporated in the bills, H.R. 1 and S. 1, introduced January 4 and January 6, 1965, respectively. Each of these bills mentioned above were known as administration bills so that every bill for hospital insurance benefits introduced since 1961 has had the approval of the President of the United States as to the administration by the Railroad Retirement Board of the program as it relates to railroad employees.

The bill, H.R. 1, which contained the agreed-upon provisions for the administration by the Railroad Retirement Board of the hospital insurance program for railroad employees, was considered by the House Committee on Ways and Means and reported by that committee as H.R. 6675, without such provisions. The reported bill was passed by the House of Representatives on April 8, 1965. The amendments of Senator Douglas would restore the omitted provisions so as to confer jurisdiction upon the Railroad Retirement Board for the administration of the hospital insurance program as it relates to railroad employees. We strongly urge the adoption of these amendments.

The restoration of the omitted provisions would be in conformity with the agreement of long standing between the Department of Health, Education, and Welfare and the Railroad Retirement Board (see statements of Secretaries Ribicoff and Celebrezze quoted earlier) and in conformity with the congressional policy of long standing to confer upon the Railroad Retirement Board jurisdiction

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[1] Hearings on the bill, H.R. 4222, before the Committee on Ways and Means, House of Representatives, 87th Cong., 1st sess., vol. 1, beginning July 24, 1961, pp. 160–161.

[2] Hearings on H.R. 3920, before the Committee on Ways and Means, House of Representatives, 88th Cong., 1st and 2d sess., pt. 1, beginning Nov. 18, 1963, p. 47, under heading of "Administration."

[3] Hearings on H.R. 11865, before the Committee on Finance, U.S. Senate, 88th Cong., 2d sess., beginning Aug. 6, 1964, p. 111, under heading of "Administration."

for the administration by the Board of all types of benefit programs for railroad employees, their dependents, and survivors.

We are informed that the Railroad Retirement Board is in favor of Senator Douglas' amendments to H.R. 6675 and we are also informed that the Department of Health, Education, and Welfare has no objection to the adoption of such amendments.

In conclusion, Mr. Chairman, we believe that there is every reason for the adoption of such amendments and we hope that this committee will act favorably thereon.

The CHAIRMAN. The next witness is Dr. Wyrth P. Baker.

Dr. Baker is representing the American Institute of Homeopathy.

STATEMENT OF WYRTH POST BAKER, M.D., M.H.D., F.A.C.P., REPRESENTING THE AMERICAN INSTITUTE OF HOMEOPATHY, THE SOUTHERN HOMEOPATHIC MEDICAL ASSOCIATION; THE AMERICAN FOUNDATION FOR HOMEOPATHY; THE HAHNEMANN THERAPEUTICS SOCIETY; THE WASHINGTON HOMEOPATIC MEDICAL SOCIETY; THE PENNSYLVANIA HOMEOPATHIC MEDICAL SOCIETY; THE HOMEOPATHIC RETAIL PHARMACISTS; THE HOMEOPATHIC MANUFACTURING PHARMACISTS; PHYSICIANS (M.D.) OF THE UNITED STATES, SPECIALISTS IN HOMEOPATHIC THERAPEUTICS; THE OHIO STATE HOMEOPATHIC MEDICAL SOCIETY; AND THE HOMEOPATHIC LAYMEN'S LEAGUE OF U.S. THERAPEUTICS

Dr. BAKER. Mr. Chairman, members of the Finance Committee of the Senate, I deeply appreciate the privilege of appearing before you today, and I have a brief statment which I should like to make. I have been practicing in Washington since 1933. I am graduate of Hahnemann Medical College, 1930, Philadelphia. I am licensed to practice in Maryland, the District of Columbia, Delaware, Pennsylvania, and Kansas. I represent the following organizations at their request: Primarily the American Institute of Homeopathy, which is the main or parent organization of the homeopathic profession: the Southern Homeopathic Medical Association, the American Foundation for Homeopathy, the Hahnemann Therapeutic Society, the Washington Homeopathic Medical Society, the Pennsylvania Homeopathic Medical Society, the Homeopathic Retail Pharmacists, the Homeopathic Manufacturing Pharmacists, and Physicians of the United States, the Ohio State Homeopathic Medical Society, and the Homeopathic Laymen's League of U.S. Therapeutics, who specialize in homeopathic therapeutics.

My subject is the omission of the "United States Homeopathic Pharmacopeia" from H.R. 6675, section 1861, paragraph (t) under "Drugs and Biologicals," page 83, line 16, following the words "the United States Pharmacopeia."

The attention of the members of this Committee is respectfully directed to the above mentioned omission and consideration of the facts which are presented below for their information.

A pharmacopeia is a book containing a list of drugs, chemicals, and medical preparations with descriptions of them, tests for their identity, purity, and strength and formulas for making the preparations, issued by an official organization.

In the United States, as well as England, Germany, France, Switzerland, India, and other countries, there are two such books; the Pharmacopeia and the Homeopathic Pharmacopeia. The most recent edition of the "United States Homeopathic Pharmacopeia" was published in 1964 by the American Institute of Homeopathy, founded in 1844, the oldest official national medical organization in the United States, which represents the Homeopathic physicians. This is the new pharmacopeia.

It is necessary to have two pharmacopeias because the technique of preparation, standardization, and dosage of drugs used by homeopathic technique may be entirely different from drugs used physiologically and some of the drugs which are most valuable when used homeopathically do not appear in the "U.S. Pharmacopeia" at all, nor in the "National Formulary" (see p. 785).

It is essential to the continued health of an appreciable segment of the population that homeopathic drugs be kept available for their use for the following reasons:

1. These drugs are effective in a wide variety of physical, mental and emotional illnesses or disorders, acute and chronic.
2. They are often more effective in certain chronic disorders than the more commonly employed physiologic drugs.
3. They are of particular value in treating elderly patients and children.
4. These drugs are nontoxic: Reactions to them are rare, poisonous effects do not occur, fatal reactions are unheard of.
5. Their use is economical; unit cost is from 0.1 to 5 percent of physiologic drugs and the amount used is in even smaller proportion.
6. Homeopathic drugs have been used since 1796 throughout the world and their use in the United States has been approved by the Federal Food, Drug, and Cosmetic Act, Public Law 717, 75th Congress and its subsequent revisions.
7. Thousands of patients and their physicians depend on homeopathic treatment for the maintenance of their health and well-being.

The size and extent of the use of homeopathic drugs is indicated by the following statistics which were compiled from the confidential reports of six of the leading manufacturers of these preparations. Each of these organizations wrote to me and gave me statistics which I have compiled.

Number of wholesale customers supplied, 1,597.
Number of retail pharmacies supplied, 47,000.
Number of physician customers supplied, 7,550.
Number of pills or tablets sold—in excess of 1,750 million.
Number of gallons of liquids sold—in excess of 30,000.
Estimate of approximate number different patients treated by physicians, 6 million.
Estimate of number of persons who use homeopathic drugs with or without the advice of a physician, 12 million.

H.R. 6675, section 1861(t) under "Drugs and biologicals" states:

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, of the medical staff of the hospital furnishing such drugs and biologicals.

The words "United States Homeopathic Pharmacopoeia" apparently were inadvertently omitted from this paragraph in the mistaken belief that the United States Pharmacopoeia or National Formulary would cover the pharmacology standards of all drugs in legitimate use. To ascertain the fact that this was inadvertently, I spoke to Mr. Wilbur Cohen, Assistant Secretary—now Under Secretary—of the Department of Health, Education, and Welfare, with whom I had a most cordial conversation, and thereafter wrote a letter to him asking the following questions:

Have your medical advisers expressed opposition to the inclusion of the Homeopathic Pharmacopoeia? Are you opposed to the inclusion of the Homeopathic Pharmacopoeia? Are the members of the Committee of your Department which prepared the bill opposed to including the Homeopathic Pharmacapoeia in H.R. 6675? If there is opposition, please give me the reasons. If there is no opposition, will you and/or the committee recommend inclusion of the Homeopathic Pharmacopoeia in H.R. 6675 to the Senate Finance Committee?

In response to this letter I received the following:

In reply to your letter of April 28, I am enclosing a copy of my letter to Congressman Broyhill concerning the inclusion of homeopathic drugs and medicines in H.R. 6675:

"DEAR JOEL: This is in reply to your letter of April 19 concerning the inclusion of homeopathic medicines in H.R. 6675. This matter did not come up in executive sessions of the House committee. We would neither favor nor oppose the inclusion of the Homeopathic Formulary among the formularies accepted for purposes of the Senate bill."

With your permission, I shall add this statement and his letter to your records.

It is essential that the United States Homeopathic Pharmacopoeia be specified following the United States Pharmacopoeia for the following reasons:

(1) The Homeopathic Pharmacopoeia sets standards for homeopathic drugs which will be used by pharmacy committees of the hospitals, insurance companies, and other organizations and agencies concerned with reimbursement for medical costs, insurance, and regulation as they apply to this medical specialty.

(2) Its omission would indicate disapproval to some organizations, particularly those insurance companies which already attempt to avoid payment for drugs used by their clients and committees which limit the choice of drugs by standardization and in the name of economy.

(3) Omission of the Homeapathic Pharmacopoeia would be inconsistent with the above-mentioned food, drug, and cosmetics law and in addition to the Healing Arts Practice Act of the District of Columbia, Public Law 831, February 27, 1929, which specifies that one member of the Board of Examiners in Medicine and Osteopathy shall be a member of the homeopathic medical profession.

(4) Its omission could prevent thousands of patients of homeopathic physicians from obtaining the drugs and treatment of their choice even though they are forced to pay for drugs which they do not want and in many cases fear.

(5) This would be a deliberate act of discrimination against an important segment of the patient community and unjustified limitation of their freedom of choice, and interference with commerce.

The members of the Finance Committee of the U.S. Senate are

respectfully requested to carefully study the proposed bill, its effects on patients as described, and if, in their opinion, the proposed change in the bill is indicated for their benefit, to take immediate action to have the words "United States Homeopathic Pharmacopoeia" inserted following the United States Pharmacopoeia.

My official positions are: president, Board of Examiners in Medicine and Osteopathy for the District of Columbia; president, Southern Homeopathic Medical Association; president, Washington Homeopathic Medical Society; president, Hahnemann Therapeutic Society; member, board of trustees, American Institute of Homeopathy; vice chairman, Department of Internal Medicine, Sibley Memorial Hospital, Washington D.C.; and member, Homeopathic Medical Society of the State of Pennsylvania.

Thank you. I am authorized to speak for these organizations.

I shall be glad to answer any questions you may have concerning this.

The CHAIRMAN. Senator Long, any questions?

Senator ANDERSON. Would you submit for the record Doctor, some examples of homeopathic drugs that are not mentioned in the compendiums mentioned in the bill, United States Pharmacopeia, National Formulary, New Drugs? If you can submit some things that are not included—I don't mean different strengths or dilutions of drugs but drugs that are not included in the other.

Dr. BAKER. I don't have a copy of the United States Pharmacopeia with me, but I have the Homeopathic Pharmacopeia. This other book, incidentally, is what we call the Homeopathic Materia Medica which corresponds to the various materia medica representing the various drugs.

Senator ANDERSON. I am trying to find out why the House might have left it out. Dr. Cohen says he neither proposes nor opposes putting it in.

Dr. BAKER. Correct.

Senator ANDERSON. But if he thought it should have been in there, he should have said so.

What is it that is left out? Could you supply us with an example of that so we may have some ideas about this?

Dr. BAKER. The homeopathic drugs are prepared differently.

Senator ANDERSON. But the drug, once approved, carries homeopathic doses.

Dr. BAKER. No, not as it appears in the United States Pharmacopeia. The dosage is different.

Senator ANDERSON. I said I know the doses are different. But if a drug is approved, it is approved no matter what dosage is given, isn't that correct?

Dr. BAKER. That is correct.

Senator ANDERSON. So if it is in the regular manual of United States Pharmacopeia, you do not have to worry about the doses.

Dr. BAKER. I shall give you a few of the drugs, for instance: baptisia, tinctora, asclepias, apis, mellifica, anacardium, orientale, alumen, lycopodium.

(The following was later received for the record:)

IMPORTANT—HOMEOPATHIC DRUGS WHICH DO NOT APPEAR IN THE U.S.P. OR N.F. (PARTIAL LIST)

Aesculus
Agnis Castis
Allium Cepa
Ambrosia
Ambra Grisia
Anacardium
Apis Mel
Apium Virus
Arum Triph
Hamamelis
Bryonia
Ignatia
Merc Sol
Gelsinium
Hydrastis
Lobelia
Chionanthus
Chelidonium
Pulsatilla
Hypericum
Chamomila
Agaricus
Anacardium
Bellis Perennis
Carbo Animalis
Cauloph Yllyum
Crataegus
Diphtherium
Drosera
Eupatorium
Hypericum
Iris Versicolor
Lachesis
Lathrotectus
Laurocerasus
Lilium Tigrinium
Lycopodium
Naja
Nux Moschata
Phytolacca
Psorinum
Pyrogen
Ranunculus
Rumex
Sabadilla
Sabina
Spigelia
Spongia
Staphysagria
Thuja
Variolinum

Senator ANDERSON. These are drugs not mentioned in the United States Pharmacopoeia?

Dr. BAKER. Yes, sir.

Senator ANDERSON. Or any of these other books?

Dr. BAKER. Yes, sir.

Senator ANDERSON. All right.

Dr. BAKER. And there are approximately 600 homeopathic drugs which I have listed in the Homeopathic Pharmacopoeia. Some are used both physiologically and homeopathically and others are used only homeopathically.

Senator ANDERSON. Thank you.

The CHAIRMAN. Any further questions?

Senator DIRKSEN. Mr. Chairman, Dr. Baker, your statement doesn't contain a definition to show the distinction between homeopathic as distinguished from physiological therapeutics nor does it contain a definition to show a distinction between homeopathic drugs and physiological drugs. Can't you give us a simple definition?

Dr. BAKER. Yes, sir; I have a statement which I submitted along with my previous statement. Homeopathy is a specialty within the practice of medicine. My education was at Hahnemann Medical College, which at that time provided two degrees: one, doctor of medicine, and the other, doctor of homeopathic medicine.

The information sheet which I supplied with this, I will read briefly so that I can save your time. It is a specialty which employs drugs which are prepared according to the standard of homeopathic pharmacopoeia and prescribed according to the certain basic and precise scientific principles based on the law of similars.

This method of therapy is practical by qualified graduates of medicine who have obtained a degree of doctor of medicine and in addition

have obtained the knowledge of this specialty either in medical college or by intensive postgraduate instruction.

The law of similars was originated or discovered by Samuel Hahnemann about 1795. Samuel Hahnemann was a physician and scholar in Germany. This law states that likes cure likes. That is, drugs which can produce certain symptoms when given in toxic dosage to a healthy person can cure illness or disease which is characterized by similar or identical symptoms. It differs from other schools of healing in the following manner:

The drugs are prescribed according to a definite symptom complex rather than for a disease entity. In other words, if we prescribe for a sore throat we take into consideration the appearance of the throat, whether it happens to be red, purple, has white patches, whether the soreness is on the right side, whether the patient is flushed or pale, whether he is toxic or active, irritable, hysterical, whether he is delirious, whether he has a swelling of the glands, and so forth, whether he is thirsty, and various other things like that are characteristic of that particular person's response to that particular illness.

Not the fact that he has tonsillitis, but the fact that he has a disturbance in his normal health which is characterized by these certain symptoms.

In the case of a pneumonia we think in terms of the patient who is perhaps very dull, toxic, has an appearance as if he had typhoid fever or whether he is very flushed, whether he is violently active or whether he is very depressed and toxic. Whether it is on the right side or on the left side, whether he is aggravated by heat, whether he wishes to be covered or whether he wishes to be uncovered, whether he is walking about the room or muttering in delirium or various other characteristics which this particular patient, by which this particular patient responds to his particular illness.

We do not treat the pneumonia, we are treating the patient who has pneumonia. That is the particular difference from physiological medication which makes use of a drug to treat a particular illness given a diagnosis.

The two schools, however, are coming closer and closer together, the concept of Hahnemann have gradually been absorbed over the years by those who practice in general medicine in the so-called allopathic or physiological field.

Does this give you the answer?

Senator DIRKSEN. You have got me more confused than ever now. [Laughter.]

The CHAIRMAN. Doctor, you have made——

Dr. BAKER. That is the unfortunate thing, when we try to explain homeopathy it is very confusing. I have a directory of the homeopathic physicians in the country, approximately 1,500 names which I shall be glad to submit to you.

The CHAIRMAN. Doctor, I don't believe you covered all the points included in the last page of your testimony. Would you like for it to be inserted in the record?

Dr. BAKER. Yes, sir.

The CHAIRMAN. It will be placed in the record at this point.

(The material referred to follows:)

INFORMATION CONCERNING HOMEOPATHY

1. Homeopathy or homeo-therapeutics is a specialty in the field of medicine which employs drugs which are prepared according to the standards of the Homeopathic Pharmacopoeia and prescribed according to precise scientific principles based on the law of similars.

2. This method of therapy is employed by qualified graduates of medicine who have obtained a degree, doctor of medicine, and in addition have obtained a knowledge of this specialty, either in medical college or by intensive postgraduate instruction.

3. The Homeopathic Pharmacopoeia is a book containing a list of drugs, chemicals, or medical preparations, with descriptions of them, tests for their identity, purity, and strength, and formulas for making them, which is issued periodically by the American Institute of Homeopathy (in the United States) founded in 1844, as the first national medical society in this country. The most recent edition was published in 1964.

4. It is necessary to have a separate Homeopathic Pharmacopoeia because homeopathic drugs are prepared by different technique and prescribed in different dosage than physiological drugs which are described in the United States Pharmacopoeia, and different drugs appear in the two pharmacopoeias.

5. The law of similars was originated or discovered by Samuel Hahnemann about 1795. It states that likes cure likes; i.e., drugs which can produce certain symptoms, when given in toxic dosage to a healthy person, can cure illness or disease which is characterized by similar or identical symptoms.

6. Homeopathy differs from other methods of healing in this manner:

(*a*) The drugs are prescribed according to a definite symptom complex, rather than for a disease entity.

(*b*) They are given in minimal or subphysiologic dosage.

(*c*) Sensitivity reactions seldom occur; toxic reactions rarely occur; fatal poisoning is unheard of.

(*d*) Each patient is carefully individualized and the drug is prescribed which is characteristic for him rather than the disease.

7. Homeopathy or homeo-therapeutics is limited in its use by the medical profession for it requires years of study to learn its technique and prescribing for the patient requires detailed and time-consuming study to select the best drug. It is therefore not applicable to empirical or mass prescribing except in a few acute illnesses.

8. It is in general use throughout the world, being particularly popular in England, Germany, France, Mexico, Brazil, Switzerland, Italy, and India. In the United States its spread has been hampered by individualism and pharmaceutical advertising of items having a much higher profit for the manufacturer in trademarked preparations.

Senator LONG. Doctor, let me ask you, I was reading the previous statement when you started on yours so it left me more confused than I was otherwise, but what is the attitude of the American Medical Association generally, that is, those who treat by the more traditional method—what is their attitude toward homeopathy, do they approve of it or——

Dr. BAKER. I have been a member of the American Medical Association since 1930. I have been a fellow of the College of Physicians since 1942. Both of which are so-called old school organizations. I have never encountered any opposition. Others may say they have. But my relations have always been most pleasant. I am president of the examining board for the District of Columbia. I have been president of the staff of Hahnemann Hospital until we merged with Sibley Hospital. I now have my staff appointment as vice chairman of the Department of Internal Medicine at Sibley, and I would hardly think that would indicate disapproval.

Senator LONG. Well, you know what their attitude is toward the chiropractors generally.

Dr. BAKER. Yes, sir.

Senator LONG. That is not the same situation here. They perhaps practice a different way but don't quarrel with whether or not you are getting results using your approach?

Dr. BAKER. I think any quarrel would be between individuals. Hahnemann Medical College in Philadelphia has met all of the standards and been more or less taken over by so-called "organized medicine." It is one of the outstanding colleges in the country at the present time. New York Medical College, Flower Hospital in New York, met all of the standards, were taken over. There previously were chairs at Ohio State University, Michigan, Boston University, and a number of others. There were several other medical colleges, but the medical curriculum is such today that it is impossible to go into the specialties. Just as it is impossible, for instance, to go into orthopedics, otolaryngology, or other specialties in the medical school. There is a basic curriculum which has to be completed and then you have to specialize afterward and that is in my opinion where homeopathy belongs today.

The CHAIRMAN. Thank you very much, Doctor.

Dr. BAKER. Thank you, sir.

The CHAIRMAN. The next witness is Dr. Victor B. Buhler, of the College of American Pathologists.

Take a seat, sir, and proceed.

STATEMENT OF DR. VICTOR B. BUHLER, PRESIDENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS; ACCOMPANIED BY OLIVER J. NEIBEL, JR., EXECUTIVE DIRECTOR AND GENERAL COUNSEL OF COLLEGE OF AMERICAN PATHOLOGISTS

Dr. BUHLER. Mr. Chairman and members of the Committee on Finance, I am Dr. Victor B. Buhler, of Kansas City, Mo., president of the College of American Pathologists. I am accompanied by Mr. Oliver J. Neibel, Jr., of Chicago, Ill., executive director and general counsel of the college.

The College of American Pathologists is a professional society of physicians representing approximately 4,500 doctors of medicine practicing the medical specialty of pathology in hospitals, medical schools, clinics, government, research, and private offices throughout the country. I appear before you today representing these physicians in support of those provisions of H.R. 6675 which provide for the payment for physicians' services in the field of pathology, radiology, anesthesiology, and physicial medicine in the voluntary medical care insurance section of H.R. 6675, title XVIII, part B, which is now before this committee for consideration. By the same token, I am appearing here today in opposition to amendments 79 and 156 to H.R. 6675 and any similar amendments which would define the professional services of pathologists as hospital services under title XVIII, part A, or provide for compensation for the services of pathologists through hospitals or other institutions. My presentation today will be confined to these important matters.

First, I would like to emphasize that pathologists are doctors of medicine. After an individual graduates from medical school he must spend at least 5 additional years in intensive training called a residency

in order that he may be certified to practice the medical specialty of pathology.

Both H.R. 1 and S. 1, as well as similar bills presented to earlier Congresses, specifically excluded "medical or surgical services provided by a physician" from the definitions of "inpatient hospital services" and "outpatient hospital services." On this basis, proponents of such legislation maintained that the bills neither interfered with medical practice, nor covered physicians' services.

This claim was not, however, totally accurate. This is because the professional services of physicians in four specialties of medicine: radiology, pathology, anesthesiology, and physiatry, were excepted from the general exclusion of physicians' services. These doctors were thus set apart from all other physicians, and these medical specialties were by implication excluded from consideration as a part of medical practice.

In passing H.R. 6675, the House of Representatives removed this adverse discrimination against these doctors by treating physicians' professional services in these specialties in exactly the same way as other doctors' services were covered.

Speaking quite frankly, pathologists would have preferred to have the total payment for their professional services placed in the voluntary insurance portion of the H.R. 6675 (pt. B), and then for the pathologist to reimburse hospitals for the space, equipment, supplies, personnel, et cetera, furnished by the institution. We genuinely believe that this would have provided maximum physician control over the medical service rendered to each patient.

However, the House of Representatives chose in enacting H.R. 6675, to provide that the costs involved in the operation of hospital beds, the laboratory, the operating room, the department of radiology, and the anesthesiology service be reimbursable as hospital costs under title XVIII, part A. Fees for the services of physicians in internal medicine, pathology, surgery, radiology, anesthesiology, et cetera, would be all paid under the same part B of the bill.

This legislative disposition is in keeping with the overall economics of the practice of medicine and acknowledges that the professional services of pathologists have been traditionally recognized as a branch of the practice of medicine just as is surgery, general practice, and internal medicine. Pathology, as well as the other three specialties, have sections in the scientific assembly of the American Medical Association; we have a recognized medical specialty examining board, and we are recognized as divisions of medical practice within the armed services, the Veterans' Administration, and the U.S. Public Health Service. State attorneys general in California, Colorado, Florida, Idaho, Illinois, Iowa, Louisiana, Ohio, Pennsylvania, Tennessee, Utah, Washington, and West Virginia have issued opinions the import of which is to deny hospitals the right to practice medicine through employed physicians. These attorneys general were following by far the majority rule that a corporation cannot engage in the practice of medicine. The status of radiology and pathology has been litigated in Iowa and the courts in that State have squarely ruled that radiology and pathology are medical practices, or services, and may not be provided by hospitals—but only by physicians in hospitals.

It is for these reasons, and others which I will discuss presently, that the College of American Pathologists accepts and endorses the

provisions of H.R. 6675 which provide for the treatment of all physicians' services alike and all hospital costs alike. The services of pathologists are not hospital services and do not belong in that portion of the bill solely designed to offer hospital benefits as would be the case in the event that amendments 79 or 156 were to be approved.

In 1965, medical practice is interdependent and high level care is based upon a balanced health team. Today, even under favorable circumstances, there is an acute shortage of practitioners in the medical specialty of pathology. In the last year for which statistics are available, pathology was only able to fill 59 percent of the number of available residences or training programs in pathology. The American Board of Pathology recommends 1 pathologist for every 5,000 hospital admissions. In 1963 (the most recent year for which figures are available) there were 26 million admissions to acute hospitals. There were only slightly over 3,000 practicing pathologists in the service practice of pathology. Thus medicine is short approximately 2,000 pathologists now.

Most of you have had an opportunity to review the report of the President's Commission on Heart Disease, Cancer, and Stroke. This report repeatedly recognizes the vital role of pathologists and radiologists in the detection of cancer and the necessity of increasing the number of physicians so trained. Pathology is the only medical specialty specifically trained for the diagnosis of cancer. All physicians recognize the importance of early detection of this dread disease. Any action by the Congress of the United States which would tend to diminish, rather than increase, the number of physicians entering this important medical specialty would deal a telling blow to our fight against this disease.

If any medical specialty, or group of medical specialties, is dealt with prejudicially in a Federal law, physicians will simply not enter these specialties. Doctors are unwilling to undergo years of extra training only to be designated as "hospital services" at the end of this training. No doctor wants to be less than a doctor. They have options to enter other branches of medicine and will exercise these options.

Previous witnesses before this committee have indicated their belief that the adoption of H.R. 6675 would be seriously disruptive to existing patterns of medical practice. This is simply not true. It is true that the exclusion of the medical services of pathologists and the other three medical specialties from the hospital segment of H.R. 6675 will result in changes in the procedure followed by some hospitals and some insurance and prepayment carriers. However, the enactment of the bill will result in many changes of a similar mechanical nature.

Pathologists practice in a variety of ways. A large number of pathologists practice their medical specialty in hospitals, others in private offices, a number in both hospitals and private offices, and still others in teaching and research. Most pathologists practicing in hospitals have an arrangement with the hospital whereby the hospital keeps a percentage of the total charge for laboratory services to reimburse the hospital for the direct (personnel, equipment, et cetera) and indirect costs involved in the operation of the laboratory. The remainder of the charge, after payment to the hospital of its cost, represents the professional fee of the pathologist. Other pathologists practice under arrangements whereby they lease space in the hospital

for a fixed percentage of the charges for laboratory services and the pathologists provide the equipment, personnel, et cetera, necessary for the proper operation of the laboratory. It is true that some pathologists are paid a salary by the hospital and the hospital, in turn, collects the total charge for laboratory services. Many pathologists thus compensated are in teaching and research. Where they are in the service practice of pathology, and the hospital is selling the services of the pathologist, as I pointed out earlier, in a large number of States such salaried arrangements are illegal. In all States this is considered unethical according to the Principles of Ethics of the American Medical Association and the Code of Ethics of the College of American Pathologists.

It is not true, as some would have you believe, that most pathologists are remunerated for their professional services by salaries paid by the hospital.

In 1956 a survey by the American Hospital Association indicated that 11 percent of radiologists and 26 percent of pathologists were still on a salary basis. All medical associations and the college have been striving to reduce this number and I am pleased to report that progress is being made.

What effect would the adoption of amendments 79 or 156 have on the existing pattern of pathology services? In effect, the adoption of either of these amendments would force all doctors practicing these four specialties to be classified as hospital services, regardless of the existing pattern of practice. Classified as hospital services, the inevitable result would be to force over 10 percent of this country's physicians to become salaried employees of hospitals rather than independent practitioners along with the rest of medicine. Such a pattern of practice in pathology, as well as the other three specialties, would be not only professionally undesirable, but in many cases illegal and in all cases unethical where the services of the physician were sold by hospitals for a profit.

Let us remember that hospitals are primarily the workshop—the environment—for the practice of medicine. The fact that such institutions provide physical facilities necessary for modern-day medicine should not furnish such institutions the impetus to take over and dominate medical practice. Hospitals cannot provide medical service. Only physicians are qualified by background, training, experience, and by law to practice medicine. The quality of medical practice cannot be determined by anyone other than an individual with such background, training, knowledge, and expertise.

It is no more appropriate that a landlord of an office building should determine the mode, method, and quality of the practice of law than should the hospital attempt to do this for the practice of medicine. The classification of over 10 percent of this country's physicians as a hospital service would place these physicians in the unenviable position of having the mode and manner of their medical practice determined by hospital administrators, hospital governing boards, et cetera, under rules and regulations laid down by Government agencies. Such a situation cannot help but produce poorer, not better, quality of medical care.

Now a word about cost. Some witnesses appearing before this committee have implied that the approval of H.R. 6675 as passed by

the House of Representatives would tend to increase the cost of medical and hospital care. A look at the record indicates that nothing could be further from the truth.

Over the past 25 years (1936–61) hospital costs have increased 405 percent, while physicians' fees have only gone up 100 percent, as compared to an overall increase in the cost of living based on the Consumer Price Index of 115 percent.

If physicians' fees in pathology and the other three medical specialties are stated separately from hospital charges, the cost of these services to patients will tend to be reduced. Reimbursement to hospitals under H.R. 6675 will be on the basis of "reasonable cost," not on the basis of "customary charges." In our opinion, hospitals will not be able to justify the hidden profits that they are now realizing, particularly in laboratory and X-ray, if hospital charges are stated separately from the physician's fee. Combining the physician's fee with the hospital charge as would be required by amendments 79 or 156 would tend to obscure and hide the hospital profit in these departments.

It has been implied by some that if H.R. 6675 is approved as now written physicians' fees in the four medical specialties involved will skyrocket and seriously increase the overall cost of medical care. As a physician, as a pathologist, as president of the College of American Pathologists, I am deeply resentful of the implication that pathologists are professionally dishonest and fiscally irresponsible so as to skyrocket their fees and exploit patients if they are allowed to charge for their own professional services along with other doctors. This does not happen with other doctors when they send their own bills and there is no reason whatsoever to suppose that it would happen if pathologists billed for their charges in the same manner as their professional brethren.

Just a word about free choice. Pathologists have been frequently referred to as "the doctor's doctor." The pathologist's principal role in medicine is that of a consultant. The selection of a proper consultant by the clinician treating the patient is an exercise of medical judgment. Were services of pathologists, radiologists, anesthesiologists, and physiatrists to be provided as hospital services, both the patient and his doctor have automatically lost freedom of choice in selecting the individual who will consult with the physician regarding the matters of medical expertise of these four named specialties. This would be true because these medical services would then be provided as a hospital service—not a medical service of the physician involved.

You have heard testimony by the American Medical Association urging the rejection of amendments 79 and 156 and that H.R. 6675 be enacted in its present form with respect to the professional services of physicians. Retention of the bill in its present form is important to all of medicine. If the services of physicians practicing in four branches of medicine are designated as "hospital service" in a Federal social security financed law, there will then exist ample precedent for including the professional services of all other physicians in this law. The result would be the complete destruction of medical practice as it is now known and a complete takeover of medical practice as it now exists by hospital administrators and their governing boards and the Federal Government through the Department of Health, Education, and Welfare.

In conclusion, Mr. Chairman, I say to you with conviction and without equivocation, that we believe the classification of the professional services of pathologists as a "hospital service" would not be in the best interests of our patients or of good laboratory medicine.

I realize that the responsibility which you gentlemen have in passing on this legislative proposal is not undertaken by you lightly. I can only sincerely urge on behalf of our membership that you seriously consider the sweeping effect of the step which you would take in dividing medicine and separating us from our clinical colleagues should you favorably report to the Senate either amendment 79 or 156.

I sincerely urge your thoughtful rejection of these amendments and approval of the provisions of H.R. 6675 which provide for payment of physician services in the fields of pathology, radiology, anesthesiology, and physiatry in the voluntary medical care insurance section of the bill (title XVII, pt. B).

Thank you, Mr. Chairman, for the opportunity that you have afforded the College of American Pathologists to make their views known to you on this important legislation.

The CHAIRMAN. Thank you very much, Dr. Buhler.

Any questions?

Senator ANDERSON. In your statement, Doctor, you say that most "pathologists practicing in hospitals have an arrangement with the hospital whereby the hospital keeps a percentage of the total charge for laboratory services to reimburse the hospital for the direct—personnel, equipment, et cetera—and indirect costs involved in the operation of the laboratory. The remainder of the charge after payment to the hospital of its cost, represents the professional fee of the pathologist. Other pathologists practice under arrangements whereby they lease space in the hospital for a fixed percentage of the charges for laboratory services and the pathologists provide the equipment, personnel, et cetera, necessary for the proper operation of the laboratory. It is true that some pathologists are paid a salary by the hospital and the hospital, in turn, collects the total charge for laboratory services."

You mention 26 percent as a portion of pathologists working on a salary basis.

Under Senate bill 1 provision for payment could be made in accordance with existing arrangements between pathologists and hospitals but H.R. 6675 would require the pathologists to submit his own bill.

Doesn't this mean that under 6675 three-fourths or more of the arrangements between pathologists and hospitals would have to be modified?

Dr. BUHLER. No, sir.

Senator ANDERSON. Under Senate bill 1 and the Douglas amendment, there would be no need to change arrangements between pathologists and hospitals, arrangements which you say cover most pathologists.

The provisions in the Senate bill 1 and parts B of H.R. 6675 would all be arrangements. Why do you then say Senate bill 1 and Douglas amendment would force the pathologists to become salaried?

Dr. BUHLER. I didn't quite get your statement, Senator.

Senator ANDERSON. Why do you say the Douglas amendment would force pathologists to become salaried employees?

Dr. BUHLER. Because the Douglas amendment provides their services would have to be as hospital services under part A and they, therefore, would be classified as hospital employees.

Senator ANDERSON. They wouldn't provide the same services now being received.

Dr. BUHLER. The pathologists who practice at the present time would continue to do so. I certainly hope that every pathologist, and I am quite sure that every pathologist, would continue with his professional competence to his greatest extent. What it would do if the bill were changed and pathologists were placed in part A and defined as a hospital service, would be to impair seriously our recruitment program. We already have a great need for pathologists. It has been estimated that there should be at least 1 pathologist for every 5,000 hospital admissions. There are approximately 26 million hospital admissions in the United States each year. We have approximately 3,000 pathologists who are in the service area of pathology. As a result, we are short some 2,000 or more pathologists at this time. To place more restrictions on the pathologist, to lower his status as a professional man, to categorize his service as a hospital service, and to divorce him from the mainstream of medical practice and from his professional brethen would certainly seriously curtail our recruitment program. It certainly would reduce the number of pathologists who would be available.

Senator ANDERSON. But you yourself say here 26 percent of your pathologists are on a salary basis, don't you?

Dr. BUHLER. They are on salary basis, that is correct. But they have been able to negotiate on a voluntary basis and have done this voluntarily.

Senator ANDERSON. And couldn't under this bill?

Dr. BUHLER. They can under H.R. 6675. But if the Douglas amendment were to be adopted, they would have to negotiate as a hospital service.

Senator ANDERSON. You talk a good deal about freedom of choice. When a patient is admitted to a hospital, just who does he choose as his pathologist?

Mr. BUHLER. The pathologist is a consultant for physicians, primarily.

Senator ANDERSON. In other words, you were talking about freedom of choice. How does a patient choose his pathologist?

Dr. BUHLER. This is what I am getting to, sir. The pathologist is a doctor's doctor. He consults primarily with other physicians. When the physician asks for a consultant, he chooses that consultant in the best interests of his patient, to provide the best type of consulting care that he can get.

Now, in the hospital he can choose the hospital pathologist. On the the outside, of course, he can chooose that same pathologist if he operates a private laboratory, or he can choose whomever he wants. It is the physician who makes the choice, and who determines the competence of the consultant he calls to see his patient.

Senator ANDERSON. So if the physician does it how does he give the patient freedom of choice?

Dr. BUHLER. The patient has freedom of choice in several ways. First of all, if a patient would want a particular pathologist to consult he could have that pathologist come to the hospital. That would be one way.

If it happens to be a specimen that can be sent to another pathologist, this is another way in which it could be done.

Senator ANDERSON. You think the average person who goes to a hospital for an operation has any choice or makes any choice of a pathologist.

Dr. BUHLER. I don't think that the patient who goes to the hospital needs to make this choice. I think that the attending physician is the one who insures that the patient gets the best of medical care. He is the one to determine, and should determine, the competence of the pathologist with whom he consults.

Senator ANDERSON. I wondered about the freedom of choice.

How are the services of salaried specialists in hospitals compensated for in the Kerr-Mills bill?

Dr. BUHLER. Senator, I would like to call your attention to my presentation.

Senator ANDERSON. Does that answer the question?

Dr. BUHLER. We are confining our remarks on H.R. 6675 to the proposed amendments.

Senator ANDERSON. You don't care to answer a question about Kerr-Mills?

Dr. BUHLER. I am not familiar with it, sir. Maybe Mr. Neibel would like to answer it?

Senator ANDERSON. I have been hearing stories about all these wonderful things about how it has been in operation. You don't care to answer any question about it.

Dr. BUHLER. You asked about how compensation is made under it?

Senator ANDERSON. That is all.

Senator LONG. You mean you don't know how your services are compensated for in your Kerr-Mills program?

Dr. BUHLER. Yes, I have an idea, but I am not here to discuss compensation under Kerr-Mills. I can say that under Kerr-Mills we submit our fee as pathologists to the welfare department, and in turn get a payment back.

This is in Kansas, which happens to be just across the State line. There is no Kerr-Mills in Missouri.

Mr. NEIBEL. I think one of the things that causes some confusion here, Senator Long, is the position that the pathologist occupies with respect to the institution in which he practices. Under the present system, which we believe would be preserved by approval of H.R. 6675 as now written, the pathologist constitutes the hospital his agent to send the bill to the patient or to the insurance carrier or what have you.

Where this procedure is followed, most hospitals' bills contain a statement to the effect that the bill for laboratory services is for the professional service rendered by Dr. X, pathologist. The fact that the hospital sends this bill does not mean that the pathologist is a hospital service. This is an arrangement whereby he has just designated the hospital as his bookkeeper because it is more convenient, more economical, for the hospital, the patient, and the pathologist to operate in this manner.

Under Kerr-Mills, the hospital bills in accordance with the arrangement that has been arrived at voluntarily between the hospital and the pathologist. In other instances the pathologist sends his own bill under Kerr-Mills.

Senator LONG. Thank you.

Senator CURTIS. Isn't it true that the Veterans' Administration and the Public Health Service, the armed services when they secure the services of a pathologist, they handle them as independent practitioners in the practice of medicine and not as a hospital service?

Dr. BUHLER. That is correct, and it is a voluntary type of arrangement, too.

Senator CURTIS. Do you know my friend Dr. Shenken?

Dr. BUHLER. I know John R. Shenken of Omaha, Nebr., very well.

Senator CURTIS. That is a good recommendation for you.

We have a similar problem in the practice of law. Many States prohibit a trust company from practicing law. If they didn't the trust company would hire salaried lawyers and a corporation would be in the business of practicing law, and they do it for one purpose, making a profit.

It has not been in the public interest and it has never been done.

What you want in regard to pathologists and these other three specialties is to retain the House language.

Dr. BUHLER. That is correct.

Senator CURTIS. It is stated by the proponents of the Douglas amendment that what they are attempting to achieve is a continuation of the present arrangement between medical specialists and hospitals.

On the face of it that seems to be the case, but I would like to ask you this question, Doctor. Would not the adoption of the Douglas amendment have the effect of giving an unfair competitive advantage to the pathologist's hospital services covered by inpatient hospital services?

In other words, his services would be paid in full, while the services of the physician who bills for his own services would be subject to the $50 deductible and the 20 percent coinsurance provision.

Dr. BUHLER. That is correct. Because the inpatient services are not subjected to the deductible and coinsurance features, this would be discriminatory.

Senator CURTIS. This would be another factor in forcing all pathologists to provide their services as hospital services rather than independent practitioners, is that right?

Dr. BUHLER. That is correct.

Senator CURTIS. Now, in your statement you make a rather serious charge about hospitals and hidden profits, what do you mean by that?

Dr. BUHLER. The cost to the hospital of the performance of a test, and the cost of the professional service, subtracted from the overall charges to the patient, is income that accrues to the hospital as profit. It is taken from those individuals who require large amounts of laboratory service and is assigned to other areas within the hospital. We submit that it is unfair to those patients who require extensive use of laboratory procedures to pay in excess of what it costs to support some other portion of a hospital activity.

Senator CURTIS. I recited here the other day that I visited a hospital in a city of 12,000 to 13,000 people, a new hospital, excellently run. I asked what their charges per bed in various categories were, and it was some $13 or $14 or $15 less than charged in larger cities.

I asked, "How are you able to do it?" I asked them if there was that much difference in their labor costs and what not. And they said,

no, they did not maintain a laboratory and the pathologist and the radiologist and so on and they informed me that it was the practice of hospitals to include that in their overall budget and then when they figured out what bed costs were that was one of the factors that went in there; is that correct?

Dr. BUHLER. Generally, that is correct.

Senator CURTISS. And a great many patients do not use a pathologist; is that correct?

Dr. BUHLER. That is right. Well, most patients who are admitted to the hospital in accordance with regulations established by the medical staff, have a certain amount of so-called routine laboratory procedures done. So, every patient, when the medical staff develops and establishes such regulations, does have some professional services of the pathologist but beyond that——

Senator CURTIS. It is minimum in lots of cases?

Dr. BUHLER. Many patients do not have the services of a pathologist, except for the routine procedures?

Senator CURTIS. Isn't it also true that the great bulk of the work of a pathologist is done outside of the hospital?

Dr. BUHLER. I wouldn't say the great bulk of the pathologist's work is done outside the hospital. I would say that approximately 70 percent of all laboratory services to patients are provided outside the hospital. Approximately 30 percent of laboratory services to patients are rendered as inservices.

Senator CURTIS. Yes. Among that 70 percent, that is a part of diagnosis and detection or possible prevention before they ever have to go to a hospital?

Dr. BUHLER. That is correct. Diagnosis, detection of disease and therapy.

Senator CURTIS. Do you think keeping the specialists in the category of the doctor is better?

Dr. BUHLER. Yes, sir; I do.

Senator CURTIS. Do you think it is better for the doctors?

Dr. BUHLER. Yes, sir.

Senator CURTIS. Do you believe it will lower the hospital costs?

Dr. BUHLER. I believe it will lower the laboratory costs. I can't say——

Senator CURTIS. If the hospital is including that as one of their overall costs they impose on other beds, it would lower it, wouldn't it, in those cases?

Dr. BUHLER. It may or it may not. It depends on whether or not the laboratory excess profits, or income from the laboratory, were being applied to other areas in the hospital. The thing that it would accomplish primarily is that it would lower the costs to those individuals who require laboratory services. It would not permit and demand that those individuals pay for other areas of hospital.

Senator CURTIS. I think you have covered the point also about its effect upon the shortage.

Dr. BUHLER. Yes, sir.

Senator CURTIS. Because as doctors look forward to their choice of specialty the fact that they would be entering a field where they would be employees of a hospital would have an effect upon the number of people coming in, wouldn't it?

Dr. BUHLER. I think it would seriously curtail our recruitment program.

Senator CURTIS. How long have you been practicing medicine?

Dr. BUHLER. I graduated in 1934, sir.

Senator CURTIS. You have been around hospitals?

Dr. BUHLER. Ever since.

Senator CURTIS. Do you think that there is anything impossible or difficult about administering the House bill as it relates to these specialties?

Dr. BUHLER. There will be, of course, a few administrative problems, but we believe, Senator, that we can make this type of bill work. This is one reason why we are here today, to endorse this section as written. We want you to know that we will make every attempt to make this a workable piece of legislation.

Senator CURTIS. Well, there will be administrative problems if they adopt the Douglas amendment, won't there?

Dr. BUHLER. There would be more serious administrative problems.

Senator CURTIS. I think so.

Now, I live in a rural area, and they have built a lot of hospitals; but most of them send their specimens or the tissue or whatever it is, to some other city for these services, and probably they would have to change some of their methods of doing business and billing people, if the Douglas amendment was adopted, because it is not part of that hospital's operation at all.

Dr. BUHLER. As it exists today, with the present wording of H.R. 6675, in those hospitals where the greatest majority of pathologists practice, there is a collection of the fee. In some instances, the hospital is designated as the collecting agency; depending upon the character of the contractual arrangement, after the fees are collected, there is a certain division of the funds, part of which are considered as professional service fees.

Under this legislation, the division would take place before billing. It would be before rather than afterward. This is the only administrative problem that would be created. To place it back in part A, or the hospital portion of this bill, would, in my opinion, make it much more difficult to administer.

Senator CURTIS. Do you think we should write a bill here that is for the convenience of bookkeeping or the best one to make people well?

Dr. BUHLER. I think we should write a bill to take care of sick people.

Senator CURTIS. Thank you.

The CHAIRMAN. Thank you very much, Doctor.

Senator ANDERSON. Mr. Chairman, I just wanted to insert into the record at this point a telegram from a hospital addressed to me saying:

I have received a telegram from the President of the New Mexico Medical Society in which he expresses its opposition and displeasure to the American Hospital Association efforts to include the services of specialists in title I of H.R. 6675. He further stated that the society deplored the action of some New Mexico hospital administrators in indicating to you their support of this amendment without prior consultation with their medical staff. My attitude is the same as that expressed in my letter of March 26, which is that it would be preferable if the bill would authorize the continuation of present arrangements between the hospitals and the specialists. If this is not possible the next best solution would seem to be to make the cost of these services an item of reimbursable hospital cost as in your S. 1 in our hospital. To eliminate these costs, would reduce the

coverage to these elderly people by approximately 20 percent. True, it would reduce the cost of the program but is this what Congress and the people want?

C. M. MARTIN,
Administrator, San Juan Hospital, Farmington, N.Mex.

I would like to put that in the record.

The CHAIRMAN. Thank you, Doctor.

The next witness is Dr. Edwin F. Daily, Group Health Association of America.

Dr. Daily, take a seat, sir.

STATEMENT OF DR. EDWIN F. DAILY, VICE PRESIDENT OF THE HEALTH INSURANCE PLAN OF GREATER NEW YORK, AND MEMBER OF THE BOARD OF DIRECTORS OF GROUP HEALTH ASSOCIATION OF AMERICA, INC.; ACCOMPANIED BY DR. W. P. DEARING, EXECUTIVE DIRECTOR OF GHAA

Dr. DAILY. Senator Byrd, I am Dr. Edwin F. Daily, medical vice president of the Health Insurance Plan of Greater New York and member of the board of directors of Group Health Association of America, Inc., and its executive committee. My office is located at HIP's headquarters at 625 Madison Avenue, New York City. With me to assist in answering questions the committee may have is Dr. W. P. Dearing, executive director of GHAA. His office is in or association headquarters at 1321 14th Street NW., Washington, D.C.

In behalf of Group Health Association of America, its member group practice plans, and specifically my own organization, the Health Insurance Plan of Greater New York, I appear in support of title I of H.R. 6675: "Health Insurance for the Aged and Medical Assistance." The board of directors of HIP representing outstanding community leaders from industry, medicine, labor, and government have specifically endorsed this bill.

Group Health Association of America is a nonprofit organization dedicated to improving the availability, efficiency, and quality of medical care, especially through the creation, improvement and expansion of group practice prepayment plans—commonly referred to as group health plans. These plans are organizations of doctors and consumers which provide comprehensive health care directly to enrolled individuals through group medical practice.

Group health plans actually provide medical service through their associated physicians and facilities and are responsible for the availability and quality of the care paid for by periodic member charges. They are thus to be distinguished from health insurance which only pays doctor bills after illness occurs, or reimburses subscribers for such payments.

There are more than 5,000 family physicians and specialists in the United States who provide medical care under such plans to over 4 million men, women, and children. They work as professional teams, pooling their varied skills in the interests of the patients. They distribute the group's income through salary partnership or other prearranged plan, but no physician in the group has a personal financial interest in any given patient or treatment, since he is not paid on a fee-for-service basis.

President Kennedy, in his health message to the Congress on February 27, 1962, said:

> Experience in many communities has proven the value of group medical and dental practice, where general practitioners and medical specialists voluntarily join to pool their professional skills, to use common facilities and personnel, and to offer comprehensive health services to their patients. Group practice offers great promise of improving the quality of medical care, of achieving significant economies and conveniences to physician and patient alike, and of facilitating a wider and better distribution of the available supply of scarce personnel.

Subsequent health messages of both President Kennedy and President Johnson have reiterated these statements.

Several hundred thousand men and women 65 years of age or older are now receiving their medical care from the doctors in these group practice plans. Our association, therefore, has a direct interest in the benefit program to be established under H.R. 6675.

Group Health Association of America has a long record of support for a social insurance approach to financing health services to the elderly. We are extremely gratified that the House of Representatives has passed H.R. 6675, which adds a voluntary supplementary benefit of specified "physicians' services" and "medical and other health services" to the basic health insurance program embodied in S. 1, introduced by the distinguished member of your committee, Senator Anderson, with 5 other of his colleagues on this committee and 39 other Senators. It was my privilege, with Dr. Dearing, to appear as representatives of GHAA before the executive conferences of the House Committee on Ways and Means in support of H.R. 1, the House counterpart of S. 1.

The addition of the supplementary program provided under part B of the present bill substantially expands the health benefits available to the elderly under social insurance. By adding physicians' services in home or office as well as hospital, it provides better balanced benefits and follows the course long pursued by group practice plans of encouraging the provision of medical care outside the hospital and minimizing the use of costly hospital facilities.

We believe, however, that the bill can and should be further improved in certain respects:

1. We are concerned about the reduction in basic social insurance benefits under H.R. 6675, which removes from coverage under part A the services provided by radiologists, pathologists, anesthesiologists, and physiatrists to hospitalized patients, and incorporates these services in the supplementary benefits under part B, with its additional premiums, deductible, and coinsurance. From the insured persons standpoint, this means that he would be denied coverage for these services essential to the care of hospitalized illness unless he elected the supplementary coverage, and then he would be subject to the $50 deductible and thereafter for 20 percent of specialists' charges for these services.

Removal of these services from the hospital under the basic program will also violate the express provisions of section 1801 against any supervision or control over the administration or operation of any institution (hospital) providing health services. Many hospitals all over the country provide these services under a variety of arrangements—contract, salary, retainer, et cetera—with the several specialists. H.R. 6675 would require all these arrangements to be revised

and would entail cumbersome administrative complications as well as interference with internal management of hospitals.

We are pleased to note that the Secretary of Health, Education, and Welfare, the American Hospital Association, and the AFL-CIO, among the witnesses before this committee, have recommended reversal of this action. Our association joins in this recommendation, which we believe would be accomplished by adoption of the amendment introduced by Senator Douglas.

2. A second major concern with H.R. 6675 is to make sure that the legislation and the administration of the benefits programs clearly allow for the continued operation of prepaid group practice plans and contain no inhibiting or hampering provisions. Many of the people who will be eligible for benefits under this bill have elected to receive their medical care from the group practice plans. The bill wisely provides that the Government not interfere with doctor-patient relationships.

Group practice plans wish to provide the benefits under this bill for those eligible persons who have elected or will in the future elect to receive their medical care from them. We believe moreover that it is in the interest of good public policy, and consistent with the recommendations of Presidential health messages to the Congress cited above, that the services which group practice plans provide to the elderly under H.R. 6675 be under arrangements which will preserve and strengthen the special features of these plans which contribute to the quality, efficiency, and economy of medical care.

Among the relevant special features are:

Payment for care on other than piecework, fee-for-service basis;

Elimination of physician's personal financial interest in any individual patient or procedure;

Integration and continuity of care—by balanced, organized medical staff of family physicians and specialists; in home, clinic, and hospital.

Inasmuch as group practice plan physicians are not compensated on a fee-for-service basis, the bill should provide for payments to a group practice plan for each of its aged enrollees by a periodic, uniform and equal contribution for all eligible enrollees on the basis of the "reasonable cost" of benefits specified in the bill. This would preserve the method of operation which group practice plans have developed to insure quality and efficiency of service and will avoid the costly and inefficient billing problems of fee for service.

3. We are also concerned because the bill under section 1862(a)(7) excludes payment for "routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids, or examinations therefor, or immunizations."

As an administrator of medical care for 30 years, I know these exclusions are not in the best interests of the people to be served. For example, the following services are excluded:

You, as an eligible person under this bill, visit your physician for a routine checkup. You are fearful of cancer that killed several relatives and friends, and you want to detect it early if you should ever have cancer. You do exactly what you should do—but whatever the cost for this examination may be, you must pay for it as it is not covered under the bill.

You have read that glaucoma blinds 5,000 persons a year in the United States, that there may be no symptoms until the eye is damaged

and that on a routine checkup, it can be easily detected early by a simple test. Well, routine checkups aren't covered under this bill—you must pay for the test.

The National Cancer Institute has contracted with HIP, a prepaid group practice plan serving 700,000 enrollees, to study the early detection of breast cancer by routine X-rays of the breast. There are 40,000 women involved in this important study costing the Government $400,000 a year. Even if we find that this new diagnostic tool does result in a lower mortality rate from breast cancer, such tests won't be paid for under this bill.

The ability to read and to hear are about the most precious assets of older people. Enormous numbers of older people put off and put off that vision or hearing examination because they can't afford it. In our experience with 13,000 older people on welfare, we find that they require more office services from eye physicians than all other medical specialists combined. Surely eye refraction and hearing tests should be covered by the bill, with appropriate safeguards to prevent abuse.

Immunizations are also excluded. When Asian flu threatened our country a few years ago, the Surgeon General of the U.S. Public Health Service urged immunization of all older people since they would be particularly vulnerable to this disease.

HIP and other group practice plans promptly followed the Surgeon General's advice and immunized thousands of our older subscribers with the Asian flue vaccine. There will be other occasions when vaccines now available and vaccines yet to be discovered will be indicated and urged for our older people. These preventive services should be covered.

In conclusion, we wish particularly to commend two important sections of the bill which have received scant attention in these hearings:

(*a*) The National Medical Review Committee, under section 1868. This Committee, if composed of courageous and informed leaders in the medical care field, can be of immeasurable help to the Government in assuring high standards of medical and hospital care.

(*b*) Under section 1875, the Secretary is mandated—

to carry out studies concerning methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care.

HIP has accurate statistics of laboratry and X-ray studies of our patients by age and place of service for the past 18 years and we will be glad to make this data available to the committee as well as the experience of our entire staff.

The Group Health Association of America will be pleased to participate with the Secretary in the studies authorized, for we are confident they will lead to great economies, while at the same time improving the quality of service provided.

I thank you for the privilege of appearing before the committee.

Senator ANDERSON. Thank you, Dr. Daily.

Two or three times in this hearing I have had occasion to refer to HIP and I want to commend you now for the fine work you have done in that general field.

You state 4 million men, women, and children are covered by group health plans. Do you have an estimate of how many of these are 65 and over?

Dr. DAILY. 250,000–300,000 would be, I think, pretty close.

Senator ANDERSON. We have heard it said by some witnesses that if Congress passes the health insurance for the aged, hospitals and doctors offices will become jammed.

HIP and other group plan have no deterrents such as deductible and coinsurance? Do you find the aged overuse the plan?

Dr. DAILY. We find just the opposite. Our experience has been that even when large numbers of people, and we are taking care of 700,000 men, women, and children now, they can have all the medical care they want, there is no cash payment, everything is paid for by the premium, there is no deterrent to it, we plead with these people to come see their doctor for routine checkups at the least signs of any illness, the problem is to get people to come to doctors. We have also had and all of the other plans have had what we consider underutilization.

Senator ANDERSON. Therefore, I am only trying to qualify you as an expert because you certainly have done some work in this field, if there was a $40 deductible in one field and some deductibles in others you would not expect that the hospitals would be jammed by these people seeking to go in for examinations.

Dr. DAILY. All I know is that the average person doesn't want to go see a doctor. Many people fear going to doctors, and they do not use the medical services that are freely available to them nearly as well as they should.

Senator ANDERSON. You mention this concern that the House bill does not provide for routine checkups or eye examination.

Do you believe there should be more emphasis on preventive medicine?

Dr. DAILY. I am sure of this, Senator. This I really think is tragic, because we do have knowledge, sir, of early detection of cancer and glaucoma and many other illnesses and how much better it is to find these things early, and be able to do something about it.

If people wait and wait and wait to go in until there are symptoms and they are really suffering it is often too late to do anything.

Senator ANDERSON. I am happy to have you say that because there has been very little emphasis on that thus far, and those of us who have been carefully watched by physicians over a long period of years know the value in being very early for your examinations and regular in going to your doctor.

The part B, the supplementary insurance program, provides a premium that will run $6 a month.

Do you think that is a realistic program? How does that compare with your charges?

Dr. DAILY. Well, we have been studying this. We haven't had time to do all of the detailed study we wished, but for the benefits provided under the supplementary program here, I believe it can be done for the amount that you have established there for the $72 a year per person. I believe it can be done.

Senator ANDERSON. Doctor, would you do this: I realize there has to be a voluntary contribution, would you survey your records again a little bit and see if there is any reason to change that testimony? The reason I say that is that there has been very little testimony given before this committee on the adequacy of the part B, $6 a month, $3 from the individual and $3 from the Government.

Some years ago, when we first were discussing health care for the aged through social security, I submitted to a well-known, very large insurance company the provisions that were in that bill and said, "If we are to provide complete coverage how much more would you have to charge for an insurance policy to cover it?"

Of course, they had to take into consideration many possibilities, whether they would be allowed to meet with other companies and try to fix the rate without antitrust considerations they would have to take into consideration what other companies were doing and so forth but they came forth with some very interesting figures which I wouldn't attempt to hold them to now, but they did indicate on the basis of what they submitted that this $72-a-year fee would be maybe a little excessive but certainly not too small, and I would appreciate it personally very much if you would take one more look and give us another answer, if you feel that is necessary.

I feel anybody who is insuring 700,000 people has some concept of what the problem is. I would be happy to have your expert advice.

Dr. DAILY. I would be glad to give you a memo on this, Senator.

(The information subsequently furnished follows:)

HEALTH INSURANCE PLAN OF GREATER NEW YORK,
New York, N.Y., May 18, 1965.

Senator CLINTON P. ANDERSON,
Finance Committee of the U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR ANDERSON: You asked me, at the Senate Finance Committee hearing on May 13, to provide you with information on the basis of HIP's experience as to the reasonable cost of providing the benefits of part B under H.R. 6675, hereafter referred to as the bill.

A review of our available data on those benefits in the bill now provided by HIP and a conservative estimate of the cost of the benefits which HIP does not currently provide confirm my statement at the hearing that $72 a year would cover the reasonable cost. The following provides a breakdown of our estimates:

Estimated cost of currently providing those benefits specified in the bill for HIP enrollees of all age groups is $44 per person per year. Available data indicate that the cost of providing these benefits for persons age 65 and over is approximately 2½ times that of the cost for our average population, or $110 per person per year. In addition, the bill specifies services not currently provided by HIP; such as, psychiatric care, home health services, and certain prosthetic appliances.

The cost for these new benefits is estimated at $15 per person age 65 or over per year or a total annual gross cost of	$125.00
Less estimated average income per person per year from a $50 deductible	36.00
Remaining cost per person per year	89.00
Less 20 percent of cost not paid by trust fund	17.80
Net cost per person per year to trust fund	71.20

The preceding estimate can be influenced by the characteristics of the aged people who might select our program. For example, if the group that selected HIP was predominantly ill, then the costs might be higher. If an unusually healthy group of people over age 65 selects HIP, it is possible that the costs will be lower.

Sincerely yours,

EDWIN F. DAILY, M.D.

Senator ANDERSON. Thank you.

Again I say I appreciate very much the information previously supplied on other occasions by HIP.

Senator Curtis?

Senator CURTIS. No questions.
Senator ANDERSON (presiding). Thank you very much, Dr. Daily.
The next witness is Mr. Diamond.

STATEMENT OF BERNARD I. DIAMOND, DIRECTOR, LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF BIOANALYSTS; ACCOMPANIED BY RALPH V. MANCINI, COUNSEL

Mr. DIAMOND. Mr. Chairman, and chairman of this committee, we appreciate and thank you for this opportunity.

My name is Bernard Diamond. I am a bioanalyst, director of the Diamond Laboratories, a bioanalytical laboratory in Philadelphia, Pa. I am director of the Legislative Council of the American Association of Bioanalysts, which is affiliated with the American Institute of Biological Sciences and the American Association for the Advancement of Science. I appear before you with counsel, Ralph V. Mancini, Esq., of Elizabeth, N.J., at the request of and representing the national association and the 13 associations listed on page 3 of the printed statement:

The American Association of Bioanalysts.
The New York State Association of Clinical Laboratories.
The New York State Society of Bioanalysts.
The New Jersey Association of Clinical Laboratory Directors.
The Pennsylvania Association of Clinical Laboratories.
The California Association of Clinical Laboratories.
The Rhode Island Association of Clinical Laboratories.
The Massachusetts Association of Clinical Laboratories.
The Illinois Association of Clinical Laboratories.
The Ohio Association of Bioanalysts.
The Michigan Association of Bioanalysts.
The Connecticut Association of Clinical Laboratories.
The Texas Association of Clinical Laboratories.
The Florida Association of Medical Laboratories.

We support the basic purpose and principles of the new hospital insurance and health care programs for the aged and the expansion of existing programs under the proposed Social Security Amendments of 1965, which is H.R. 6675, now before you for consideration.

As presently written in section 1861(p) the bill limits payment for outpatient bioanalytical laboratory services to those furnished by and through hospitals accredited by the Joint Commission on Accreditation of Hospitals. Consequently, the vital services offered by the many nonhospital, independent bioanalytical laboratories throughout the country, serving over 50,000 physicians and their 20 million patients per year, are peremptorily and arbitrarily excluded from the integrated team of available and qualified facilities on which total health care is predicated.

There is precedent in many States for the payment of fees to independent outpatient laboratory facilities by Blue Cross, Blue Shield, State departments of health, State departments of welfare, Federal agencies, such as the Veterans' Administration (Armed Forces medicare program), and other insuring agencies.

In this respect, therefore, the bill is clearly inconsistent. The many independent laboratories in the United States are directed by clinical chemists, microbiologists, and others specially educated and trained to perform analyses of materials from biological sources, primarily

human, for the licensed practitioners of the healing arts, to facilitate their diagnosis and treatment of patients.

Readily available statistics indicate that there are not enough physicians specializing in laboratory work to fill present diagnostic test demands by the medical practitioner. Consequently, without the aid of presently existing independent laboratories, both M.D. and non-M.D. directed, the workload must of necessity make effective performance and supervision increasingly difficult. The public should be served by every qualified facility available in the community. This involves not only the care of the hospitalized patient by the physician, nurse, and hospital staff, but also the care of the at-home patient by whatever means the physician chooses as the most effective.

The proposed bill should be effective in operation, as well as sound in concept. It will be neither if available and qualified services and facilities, which are now satisfactorily serving the public under State-imposed safeguards, are to be excluded. We agree with a principal aim of the proposed bill—to provide the aged with insurance protection against hospital costs, and in addition, to cover certain health services which, where medically feasible, are a less expensive and more reasonable and practical alternative to inpatient hospital care. But the exclusion of the services of the many independent bioanalytical laboratories is neither just, reasonable, practical, nor necessary. The independent laboratory at the present time is already rendering essential services to both the physician and his patient, under the physician's direction.

Why does the nonhospital, independent laboratory exist? Because in many cases it is the only qualified agency conveniently available to the public. Because the independent laboratory director is most attentive to the needs and demands of both physician and patient, and better prepared to meet emergencies and special, individual circumstances, such as those requiring house calls for testing.

Because the hospital laboratories alone cannot handle the ever-increasing volume of testing demanded by the physicians. Because there develops between director and physician a personal and most cordial relationship of mutual trust and confidence. Because the very economic life and continued existence of the independent laboratory depends entirely upon the extent to which it and its director continue to earn the confidence of the referring physician.

Here, in the exercise of the free choice and judgment of the physician, lies the greatest assurance of high quality and safe testing upon which to predicate effective patient treatment.

The proposed bill arbitrarily deprives both physician and patient of the right of free choice of qualified, competent laboratory facilities, despite the provision of section 1802, entitled "Free Choice by Patient Guaranteed." The independent laboratory does not receive or request public funds and grants for equipment and facilities. They are tax-paying organizations, and therefore carry their fair share of the burden of government. Nevertheless, their fees and charges remain comparable with and frequently even lower than those charged by the hospital laboratory, which, although the hospital itself is tax exempt, like the independent laboratory is a profitmaking enterprise.

In any case, the bill would require official approval of fee schedules for all laboratories covered by it.

The proposed hospital insurance program is based upon the conception of "institutional" responsibility for the provision of services and the assurance of appropriate standards. The requirement of hospital responsibility is aimed at assuring payment only for "medically necessary" services and that the services actually rendered are subject to responsible supervision and control.

Gentlemen, whether a hospital or independent laboratory, only the physician can determine the "medical necessity" for diagnostic services. Only the physician directs when and what kind of laboratory tests shall be performed. Only the physician interprets the laboratory report and is guided thereby in his diagnosis and treatment.

The referring physician must himself determine whether such services are subject to responsible supervision and control rendering them reliable aids in his treatment of his patients. We do not disapprove the concept of "institutional" responsibility. Rather do we seek to broaden that concept to make it practical and realistic. Nowhere in the bill does it appear that the competence and qualifications of the physicians of the Nation are cast into question or dispute. Accepting, then, the qualifications of our physicians licensed under State law, and accepting, too, the fact that a patient must be referred to a laboratory for diagnostic services by such a licensed physician, we respectfully urge that the physician is in final fact the most realistically effective "institution" to assume responsibility for the work of the laboratory to which he has referred his patient. The physician has been effectively assuming that responsibility.

Why, then, must we now preclude him in these new programs and create a substitute "institution" to impose its judgment with respect to laboratories upon him and his patients?

Who in the hospital is actually to assume and implement its institutional responsibility—the nurse, the lay director, the intern? Why is the individual physician, adjudged competent for all other purposes pertaining to his profession, in this respect only adjudged incompetent or unreliable? The inescapable fact is that only the physician can, in practice, assume that responsibility to this patient. We submit that he can and does discharge that responsibility to all his patients, whether in hospital or out, and whether as a hospital staff member or individual practitioner. His integrity and judgment are, in either case, the protection upon which his patient must rely. To substitute the impersonal entity known as a hospital for the individual physician as the institution upon whose responsibility laboratory testing fees will be recognized for payment under the proposed bill is arbitrarily to deprive the medical profession and the public of an essential member of the integrated health team.

In conclusion, we therefore recommend and request your consideration of an amendment of the proposed bill, section 1961(p) to provide for direct payment for services rendered by any bioanalytical laboratory licensed, certified, or otherwise recognized or approved by appropriate State action.

Thank you very much.

Senator ANDERSON. Thank you, Mr. Diamond.

I would like to say that I appreciate very much the way in which this testimony is put together.

Mr. DIAMOND. Thank you, sir.

Senator ANDERSON. It is legible, easy to read and pleasant to read and I appreciate it very much.

Mr. DIAMOND. Thank you.

Senator ANDERSON. Senator Douglas?

Senator DOUGLAS. At the conclusion of the questioning of the witness, I would like to make a statement for the record but I think probably it would be well if I did not question the witness.

Senator CURTIS. No questions.

Senator ANDERSON. No questions.

Senator Douglas?

Senator DOUGLAS. Mr. Chairman, I have noticed in recent testimony and press reports a growing amount of inaccurate comment on the amendment relating to the hospital services of medical specialists which I introduced for myself and a number of Senators.

First, these attacks on the amendment allege that it would remove coverage of the services of medical services from the voluntary plan, part B, and force coverage of these charges solely under the basic hospitalization plan, part A. This is certainly a misunderstanding.

The fact is that the amendment would permit coverage of these medical specialist services under the basic plan, part A, if the hospital bills for the services and if, for example, the specialists are paid a salary by the hospital or receive a percentage of the income of that department.

But if the existing or future arrangement is that the specialist renders an individual bill to the patient, then the charge may be covered under the voluntary plan. Under the voluntary plan, of course, coverage is conditioned by the $50 deductible in the calendar year and the 20-percent coinsurance feature.

Second, a charge is being made that the amendment would interfere in a matter between the doctors and the hospitals, and that it would force doctors into a salaried position under the direction of hospital administrators. The contrary is true. The amendment would simply permit coverage under either the basic plan or the voluntary plan depending upon the existing or the future arrangements which the doctors work out with the hospitals.

Since there would be coverage of their services under either the basic plan or the voluntary plan, the law proposed by H.R. 6675 would not interfere with the voluntary arrangements worked out by the hospitals and the doctors. I think that should be the amendment proposed to H.R. 6675.

In fact the opponents of the amendment are the ones actually asking the Federal Government to interfere in these arrangements. They insist on the less complete coverage restricted to the voluntary plan which would directly interfere in any present arrangements where the hospital bills the services of the specialists.

The opponents want to use the law to force the hospitals into changing their arrangements with the specialists.

Third, the opponents, I think, reflect improperly on the American Hospital Association and American hospitals, in general. In their press statements they somehow charge that the support of these bodies for the amendments is greedy and profit motivated. I will only say that the facts show that about 90 percent of the hospitals are nonprofit organizations. Only about 10 percent are profit hospitals. And I don't think they can be charged with being greedy.

I doubt that 90 percent of the members of AMA are nonprofit professionals.

In summary, the amendment would permit reimbursement under the basic hospital plan for the hospital services of radiologists, pathologists, anesthetists, and physiatrists only where the specialist receives payments for his services from the hospital rather than rendering his own separate bill to the patient. Nothing in the amendment interferes with the coverage of his services under the voluntary plan if he renders individual bills nor does the amendment take one side or the other in what the arrangement is to be between the hospital and the specialist.

I hope this clears this matter up. If there is any confusion in language, we will be very glad to meet with representatives of these specialties. I want to make it clear this does not mandate that the four specialists must come under plan A, but it does permit the doctors and hospitals to agree instead of compelling them to be under plan B.

Senator ANDERSON. I appreciate that fact that you made that statement, Senator Douglas. I tried to point out this morning to one witness his own testimony said that 26 percent were now receiving salaries and were acting in that capacity. All the Douglas amendment says as I understand it is whatever the arrangement is now it shall be allowed to continue if the hospital wants it that way.

That is what the people in my State have objected to, I think they object to others, a provision which wipes out that right.

Paul D. Hill?

Senator DOUGLAS. Excuse me.

I want to be sure you know that, to clarify this point, we introduced a second amendment, 156 to replace 79. The purpose of 156 was to make it even clearer what the intent is, and I wish our friends would address themselves to 156 and see if this meaning is now clear.

Certainly the intent is as I have just described it.

Senator ANDERSON. I think those people who testified this morning on this should have an opportunity, perhaps before they leave, to see the testimony which has been given and see if they have any comments to make in view of what Senator Douglas has said, because I fail to see how it disturbs what they were talking about, freedom of choice and things of that nature.

Mr. NEIBEL. Mr. Chairman, do I understand the College of American Pathologists then will be afforded an opportunity to comment for the record on Senator Douglas' statement?

Senator ANDERSON. Yes, sir; Mr. Neibel, they will be allowed.

Mr. NEIBEL. Thank you very much, Mr. Chairman.

Senator ANDERSON. I think, Dr. Buhler, it will be very important that you do it because the wrong impression is sort of left somewhere we are not reading the same book.

Senator DOUGLAS. I wish they would look then at amendment 156 rather than 79.

Senator ANDERSON. Let me just say when we start to work on this bill in the committee, I am sure the able Senator from Virginia, Senator Byrd, will want to consider all these proposals that have been made, will want to consider all objections that all these people have raised, and if you have raised an objection to one amendment, and a new one has been prepared to clarify the situation, it will be very helpful to him and other members of the committee.

Therefore, I hope you will have an opportunity to look at what Senator Douglas has just now said and what he has thus far introduced and see if it does not resolve the situation to some degree. There are those who would like to have us pass legislation which would throw all these people under hospital care. Others want to take them all out of hospital care. It is pretty hard to say why the ones who are now there on the hospital payroll should not be allowed to stay.

If it is your desire to take them off that salary list, then you ought to say so, it seems to me, frankly that is what your purpose is.

If it is possible to work out in a satisfactory fashion that problem, we would all be better pleased. So if you will consider the statement, fine.

Mr. NEIBEL. We will be pleased to submit a supplementary statement. Thank you.

(The document referred to follows:)

(The following statements were subsequently submitted for the record regarding the above relating to Senator Douglas' amendment No. 156:)

COLLEGE OF AMERICAN PATHOLOGISTS,
Chicago, Ill., May 18, 1965.

Senator HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Following the appearance of the College of American Pathologists' witness, Dr. Victor B. Buhler, and at the close of the hearings on May 13, 1965, Senator Douglas of Illinois read a statement for the record concerning his proposed amendments to H.R. 6675, amendments Nos. 79 and 156.

At the conclusion of Senator Douglas' statement, upon the request of Mr. Neibel, general counsel of the College of American Pathologists, both Senator Douglas and Senator Anderson (who was then presiding) invited the College of American Pathologists to submit a supplementary statement for the record, further explaining our position with respect to the proposed amendments Nos. 79 and 156 and commenting on Senator Douglas' statement. This letter is being written in compliance with this request and we respectfully ask that it be made a part of the record of the hearings of the Senate Finance Committee on H.R. 6675.

In large measure, the objectives sought by those sponsoring amendments 79 and 156 and the objectives of the College of American Pathologists are apparently similar. Both the sponsors of the amendments and the college desire that if Federal legislation is enacted, providing medical and hospital care for the aged, that such legislation will be in the manner and form which will be least disruptive to existing arrangements between physicians and hospitals and other institutions. Those sponsoring the amendments believe this objective would be best accomplished by adoption of the proposed amendments. The College of American Pathologists is of the opinion that this objective is best achieved by approving H.R. 6675 as presently written with respect to physicians' services whereby the professional services of all physicians are treated alike and all hospital costs are likewise treated in the same manner.

We have carefully examined both amendment No. 79 and amendment No. 156 and cannot find any significant difference between these two amendments. Both of these amendments would provide that the professional services of doctors of medicine practicing in the fields of pathology, radiology, physiatry, and anesthesiology would be classified as "hospital services" and payment for the services of these physicians would be in the same manner and mode as payment for hospital costs. Both of these amendments would separate the four medical specialties involved from the mainstream of American medicine and make physicians practicing these specialties something less than a doctor.

At the outset, we believe that it is important to recognize that H.R. 6675, as presently written, will not alter or disrupt a single arrangement between any physician and any hospital. Those who choose to practice on a salary, a percentage of the gross or net, or on a lessee basis may continue to do so. The bill

as now written does not give preferential treatment to any particular arrangement between physicians and hospitals. The charge that enactment of this legislation will result in widespread renegotiation of contracts is simply not true. The bill merely requires that these four physicians' services will all be billed under part B of the bill and hospital costs will all be billed as hospital services under part A of the bill. What is done with the fees and costs collected under part B and part A, respectively, is subject to any arrangement which the physician and hospital might work out to their mutual advantage and the advantage of the patient.

We readily admit that if either amendment 79 or 156 were to be approved, that the professional services of pathologists, radiologists, anesthesiologists, and physiatrists would be available to those over 65 in both part A (hospital services) and part B (physicians' services) of the bill. It should be recognized, however, that hospital services under part A of the bill are only subject to a $40 deductible for inpatient diagnostic services and only a $20 deductible if such services are to be provided to a patient as an outpatient. After these deductibles have been satisfied, both physicians' fees and hospital costs are paid in full. Contrast this benefit pattern with the benefits provided under part B of the legislation. Professional services rendered and billed under this part are subject to a $50 annual deductible and 20 percent coinsurance for all charges billed after satisfying the deductible.

The differences in benefits under part A and part B of the bill make any alleged freedom of choice for the physician illusory. A careful reading of the testimony of the American Hospital Association cannot help but reveal that hospitals will bring almost insurmountable pressures to bear upon physicians to have them provide their services as a hospital service and to have the hospital bill the patient for the service thus provided. If the physician resists, he will be accused of holding out on the old folks inasmuch as the same services will cost the individual patient more if rendered as a physician's service under part B of the bill. Furthermore, as indicated in our testimony before the committee, over 70 percent of laboratory procedures are now performed outside the hospital. Were these services to be provided "free" as hospital inpatient or outpatient services after a minimal deductible is satisfied, the result cannot help but be to magnetize patients from the private practice sector into the hospital for there the bills for services rendered will not be subject to the 20-percent coinsurance requirement and the larger deductible. Accordingly, it is the position of the College of American Pathologists that adoption of amendments 79 and 156 would be extremely disruptive to existing patterns of medical practice, add immeasurably to the costs of the social security financed program, separate physicians practicing the four named specialties from the rest of medicine and inevitably result in hospital domination of medical practice in these four areas.

Now a word about "hidden profits." It is true that most hospitals are "nonprofit" organizations. It is also true that these nonprofit organizations have been ringing up the cash register with profits in the laboratory and X-ray departments. This does not mean that hospitals generally are overall making a profit. What is does mean is that patients needing diagnostic X-ray and laboratory services are subsidizing patients not needing or utilizing these services.

Let us look at some figures. According to Hospital Administrative Services (a nonprofit organization affiliated with the American Hospital Association) for the month of December 1964 in hospitals with between 200 and 299 beds, the median laboratory accounted for 11.4 percent of the total income of the hospital while the expense of operating the laboratory (including the professional services of the pathologist) were only 6.9 percent of total hospital expenses.

We believe in any federally financed program that hospital costs and physicians' fees should be laid on the table for all to see.

Where hospitals are making a hidden profit in laboratory and X-ray, the charges for these services to patients should be reduced. Patients needing these services should not subsidize other areas of hospital operation. The best way we know to accomplish this is by approving H.R. 6675 as now written, so that hospitals can be paid "reasonable costs" of providing laboratory and X-ray services, and the professional services of physicians in these areas may be compensated along with other physicians in part B of the bill.

Finally, it has been charged that failure to approve amendments 79 or 156 will result in the denial of substantial benefits to those over 65 in need of medical and hospital care. Let's look at the facts. For purpose of illustration, assume a total hospital bill of $1,040 (much larger than the average hospital bill of individuals over 65). Approximately 20 percent or $200, after the hospital deducti-

ble is satisfied, on the average will go for laboratory and X-ray services. Assume that 60 percent or $120 is the hospital cost of providing the services and 40 percent or $80 is the professional fee of the pathologist and radiologist. With a hospital bill of $1,000, certainly the annual deductible of $50, under part B, would already have been paid to other physicians. Thus, the aged patient would have to pay to the pathologist and radiologist 20 percent (the coinsurance factor) of $80 or $16. It does not seem reasonable to say that payment of $16 out of a hospital bill of $1,040 is a substantial reduction in benefits.

In conclusion, we would like to state once again that we are of the firm conviction that passage of H.R. 6675, with respect to physicians' services and hospital costs, will result in the greatest freedom for physicians and hospitals to negotiate their own arrangements, will not segregate a substantial segment of physicians from their professional brethren, will not operate to dissuade young doctors from entering these specialties, will tend to lower costs, and will be in the best interests of patients, doctors, hospitals, and the Federal Government.

Thank you, Mr. Chairman, for the opportunity you have afforded us to extend our remarks before your committee.

Respectfully,

OLIVER J. NEIBEL, JR.,
General Counsel.

THE AMERICAN COLLEGE OF RADIOLOGY,
Chicago, Ill., May 17, 1965.

HON. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Old Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: On May 13 Senator Paul H. Douglas presented a statement for the record of the hearings of the Senate Finance Committee on H.R. 6675. Later, from the chair, Senator Clinton P. Anderson invited comments for the record on this statement and on amendment 156. With your permission, the American College of Radiology offers the following comment for the record of the hearings:

1. Under amendment 156 payments for physicians' services in pathology, radiology, physiatry, and anesthesiology are available to hospitals in part A if the hospital bills for the services of these physicians as hospital services, and payments for physicians' services in these specialties are available under H.R. 6675 in part B if the physician bills for his services as medical services. Total hospital costs under part A are, however, subject only to a $40 deductible if the individual is a bed patient, or $20 if he is an outpatient, and then are covered in full. In contrast, physicians' charges under part B are subject to a $50 deductible and are then subject to a coinsurance provision under which the patient is liable for 20 percent of reasonable charges. This fact that payments for physicians' services in the specialties cited are less expensive to the covered individual under part A than under part B—if the Douglas amendment is enacted—will be used by hospitals to pressure the physicians involved into permitting the hospital to bill for their services. If the physician resists, he will be accused of "holding out on the old folks," depriving the aged of possible benefits, etc. These pressures can be anticipated on the basis of testimony presented by the American Hospital Association and statements of many hospital administrators.

2. It has been implied and stated that H.R. 6675 as written will require physicians and hospitals to renegotiate current arrangements under which physicians receive salaries, lease space in a hospital, or have some sort of contract calling for a sharing of collections on a percentage basis. Insofar as the language of the bill is concerned, H.R. 6675, if enacted, will not alter, or disrupt, so much as one such arrangement between one doctor and one hospital. H.R. 6675 only requires that all physicians designate reasonable charges for their services, accept responsibility for the level of these charges and collect these charges in the form of physicians' fees. H.R. 6675 does not deal with the disposition of fees after they are received.

Today, without reference to any legislation, all physicians on the staffs of a number of hospitals present patients bills for their services, collect these bills, assign collections to the medical school or hospital, and receive salaries from the medical school or hospital. H.R. 6675 will not change this practice arrangement of any internist, general surgeon, radiologist, etc. H.R. 6675 treats all

physicians and all hospitals alike insofar as presentation of reasonable charges is concerned; no physicians are specifically placed in an administratively disadvantageous position insofar as hospital relationships are concerned; but the bill does not interfere with physicians or hospitals in evolving locally satisfactory practice arrangements.

3. Those hospitals that are not-for-profit corporations could not be characterized as greedy. It is true, however, that under the single charge billing system in radiology that reimburses the hospital and the doctor's fee in one payment, patients who need radiology services pay charges in excess of costs of delivering the service plus the fee for the service. A patient who has a $10 radiology charge under this system is paying the hospital $5 for the accountable costs; the physician a fee of $3.50 to $4; and the hospital an excess amount of from $1 to $1.50 which is applied to underpriced services provided some other patient. This excess of charges to a patient over all costs of serving that patient is the hospital "profit" that has been mentioned. The principal, indirect beneficiaries of H.R. 6675 with its requirement that physicians' fees and hospital costs be separately stated will be patients not covered by the bill. This is because excessive hospital charges for these services will become apparent when stated separately from the doctor's fee, and this fact will tend to reduce costs of radiology, pathology, etc. for the 90 percent of Americans who are not beneficiaries of H.R. 6675. It would seem that there is little reason to perpetuate a system that charges John Doe, an outpatient who needs an X-ray chest examination, an excessive amount for the benefit of Richard Roe who is occupying a hospital bed.

4. Some Senators have expressed a concern that H.R. 6675 has materially reduced the benefits proposed under S. 1. If you assume, as virtually all witnesses have assumed, that nearly all eligible will voluntarily enroll in part B, H.R. 6675 would not seem to materially reduce benefits in the cited specialties. Further, of course, H.R. 6675 has added under part B the full range of physicians' services, and this is all a plus.

To illustrate: assume a large, $1,200 hospital bill; assume radiology charges of 9 percent of this bill and pathology charges of 11 percent, or $108 and $132, respectively (in keeping with insurance company experience). Fifty percent of the $108 radiology charge and 60 percent of the $132 pathology charge, or $133, will be reimbursed to hospitals under part A of the bill as written as "reasonable costs." Even if we assume the physicians' fees to be the remainder, or $107, the amount payable by the patient is only $21.40, or 20 percent, because any patient with a hospital bill of $1,200 will have other physicians' charges that will satisfy the $50 deductible under part B. If we assume that the fees of radiologists and pathologists will be set at levels approximating 35 percent of the present charge of $240, or $84, the patient will be personally liable for just under $18. It is believed that a requirement to pay an added $20 in a situation involving a hospital bill of $1,200 is not a substantial reduction in benefits.

As another example, assume a patient who requires radiology and pathology services costing $200 on a not hospitalized basis and that his patient is referred to a radiologist and a pathologist at a hospital for these services. The patient pays a $20 deductible and a little more than half of the remaining $180, or about $100, is reimbursable to the hospital as "reasonable costs." Again, a patient requiring radiology and pathology services of this magnitude is certain to have other doctor bills in excess of $50, and thus the patient will be personally liable for 20 percent of $80, or $16. If we again assume that the fee of the radiologist and pathologist will be set at 35 percent of $200, or $70, the patient will be personally liable for $14. This again would not seem to be a substantial reduction in benefits.

In addition, in either instance, if the patient is truly medically indigent, he would in most States receive aid under the Kerr-Mills law.

As noted in a statement submitted to the committee, our principal objections to amendments 79 and 156 are medical. They center upon our recognition of increased medical service and recruitment difficulties we face if either amendment is incorporated into H.R. 6675. We are interested only in high-level radiology services for patients now and in the future. We cannot now provide such under hospital domination and we cannot recruit bright young doctors to provide such in the future if we are segregated from the mainstream of medical practice under a Federal law.

Thank you very much for the opportunity of offering this comment.

Sincerely,

WALLACE D. BUCHNAN, M.D., *President*.

Senator CURTIS. Mr. Chairman, I have an appointment. It is now 12:30, and I cannot stay here. I wanted to ask some questions. But I want the record to show—I cannot ask them now. I just want the record to show that I will pursue his testimony, and I am glad he is here.

Senator ANDERSON. Senator Curtis, if you desire we will ask permission now that you may submit some written questions to Mr. Hill, and if he desires to answer them for the record he may do so.

Senator CURTIS. I do not think I will avail myself of that. I have to go.

Senator ANDERSON. Paul D. Hill?

STATEMENT OF PAUL D. HILL, COCHAIRMAN, LEGISLATIVE COMMITTEE, INTERNATIONAL ASSOCIATION OF HEALTH UNDERWRITERS; ACCOMPANIED BY ROBERT FINNEGAN, MANAGING DIRECTOR

Mr. HILL. Mr. Chairman, I am Paul D. Hill, of Indianapolis, cochairman of the Legislative Committee of the International Association of Health Underwriters.

With me is Robert Finnegan, of Chicago, who is the managing director of the International Association of Health Underwriters, and we are well aware that in order to be eternal any statement does not have to be interminable, and we think you gentlemen have been extremely patient this morning.

Mr. Chairman and members of the committee, this is the statement of the International Association of Health Underwriters, the professional agents' organization made up of men and women who sell and service health insurance all over the country. Our association is composed of about 5,000 members in nearly 100 State and local organizations blanketing the United States. It is the members of our organization, along with the members of the National Association of Life Underwriters and the property-casualty insurance agents who sell and service the insurance plans that today are used so widely to offset the costs of hospitalization, surgery, and doctor's bills, and to replace earned income during periods of disability due to sickness or accident. Our position, which we were privileged to present in person to this committee last year, is this: We favor the best medical care available for every person in these United States, regardless of his or her age, and regardless of his or here ability to pay for it. We further believe that every individual should use his own resources before he should turn to any public program at the Federal, State, or local level. It is the duty of the public at large to provide for those who are financially incapable of caring for themselves; it is not the duty of the public at large to tax everyone to pay for medical costs of those who are able and in most instances willing to pay their own expenses. This being true, we believe that the present Kerr-Mills law should be expanded to every State, and that it should be broadened to cover any demonstrable and proven need for medical care among those age 65 and over in our population.

At the same time, we are totally opposed to socialistic programs whose avowed goal is to cover everyone, regardless of need, and whose ultimate purpose, as stated by their most vocal adherents, is to make

the Federal Government the prime controller of medical care in our country, not only for those age 65 and over, but eventually for everyone, regardless of age. This purpose has probably never been more openly and blatantly stated than by Wilbur Cohen, Assistant Secretary of Health, Education, and Welfare, when he said—

> the ideal in social benefits will be reached when each individual is paying as much in social benefit taxes as he is paying in income taxes.

For most Americans, a tax burden of this type would be completely unbearable.

Why are the members of our organization, along with many millions of other thinking Americans, so opposed to H.R. 6675?

First of all, there is no demonstrable need for legislation of this type. Today, there are about 18 million people age 65 and over in our country. About 11 million of these are covered against the costs of hospitalization by voluntary health insurance. A large percentage of these also have insurance plans that pay the costs of surgery. And more are covered for doctor bills, also. Millions of people in this age group are quite capable of paying their own hospital and medical bills, and do not feel a need even for health insurance to help them. Proponents of the medicare concept have, in testimony during these and previous hearings, repeatedly derided these health care plans, pointing constantly to the fact that they do not offset every last dollar of expense, and to the fact that many people 65 and over do not have the money to pay the necessary premiums. In so doing, they have deliberately glossed over the facts that (*a*) many people prefer insurance that will pay larger medical and hospital bills, not insurance that will provide first-dollar coverage; (*b*) that many people can pay their own bills without insurance of any kind; and that (*c*) a certain segment of our people will always spend their money for pleasures and then turn to society as a whole for the basic costs of living.

Those who need help with their hospital and doctor bills should receive it; no bill should be passed to cover everyone regardless of need.

This lack of need is further illustrated by a look at the assets of the people in the group to be covered by this bill. Statistics compiled by our Federal Government show that the average family whose head is 65 or over has assets of $30,718. Only one other group has a higher average net worth, the 55- to 64-age group, with $34,781 in assets. By comparison, Government statistics show that where the family head is 25 to 34, the average net worth is $7,661; where the family head is 35 to 44, the average net worth is $19,442; where the family head is 45 to 54, the average net worth is $25,459. Thus, the 65-and-over age group is second only to the 55 to 64 group, and ranks in assets substantially above all the others. Perhaps we are proposing medicare for the wrong end of the age scale. This same fact is borne out by a study of hospital records, which shows that fewer than 5 percent of people 65 and over do not pay their bills, whereas the percentage in younger age groups is many times as great.

Fabian Linden, manager of consumer research at the National Industrial Conference Board, speaking of people 65 and over, states:

> They form a rapidly expanding market of impressive proportions that constitutes a solid plus for the overall economy.

A recent article by Alfred L. Malabre, Jr., writing in the Wall Street Journal, states:

> The record shows that a very large portion of the net worth of older persons is concentrated in assets that can readily be turned into cash to buy things. For example, $4,670 of the $30,718 average for the 65-plus group represents such liquid assets as savings and checking accounts. This is a good deal higher than the comparable liquid asset total of any other age group. Similarly, such investment assets as stocks and bonds account for $13,782 of the elderly group's average net worth. In no other age group is the comparable figure nearly so high; only in the 55 to 64 bracket, in fact, does the investment asset total reach even half the average of older persons.
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> The assertion sometimes is made that the assets of the elderly are bunched among relatively few very rich old persons. On this premise, it is argued that the 65-plus group as a whole lacks the very great buying potential suggested by an average net worth of $30,718.
>
> Government figures show, however, that the elderly are relatively well off even if the yardstick used is a median rather than average net worth; the median worth of an age group marks the level at which half the families have a higher worth and a half a lower worth. The median net worth of the 65-and-over category is $10,450, nearly $3,000 above the median for all families, 5 times the median for families in the 25 to 34 bracket and 30 times the figure for families whose head is less than 25 years old.
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> At the same time, the debt load of older persons is unusually small. Of the 65-plus families that own homes, less than one in five owes any mortgage money; the comparable ratio for all homeowning families exceeds one in two. Moreover, 82 percent of elderly families owe no installment debt. This compares with a debt-free rate of only 66 percent in the 55 to 64 age group, and 50 percent or less in all families under age 55.
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> To be sure, the actual income of elderly persons is relatively small; half the Nation's 65-and-over families earn less than $2,875 yearly, according to a recent Social Security Administration report. By its nature, however, the income of older persons appears remarkable secure—a fact that would obviously take on major significance if the currently brisk pace of business should falter. More than half the total income of the elderly derives from social security and other public and private old-age benefits. Another 15 percent of older persons' income represents interest, dividends, and rent. Thus, less than a third of the earnings of the 65-and-over families is tied to such relatively vulnerable sources as the weekly paycheck.

Can this possibly be the same group of American citizens the proponents of medicare point to when they talk about the need that is so prevalent?

The second reason we oppose this bill is that its costs are not fully known and when they are realized will be so high that they will be an intolerable burden to the wage earners of our country. During the years medicare plans have been discussed in Congress, representatives of Health, Education, and Welfare Department have constantly revised upward their cost estimates, but always reluctantly and always after their published figures have proven incorrect. Current estimates are that the "package of benefits" presently proposed will cost $1 billion in 1966, and $2.3 billion in 1967. More realistic appraisals indicate that the true costs could be twice these amounts—and perhaps even more. Dr. Barkev S. Sanders, medical statistician, sociologist, and psychologist who has made a number of estimates of costs for the Social Security Administration in earlier years, states that medicare benefits will cost at least three times as much as today's official estimates and could eventually cost 10 times as much.

Social security was originally conceived as a plan to provide a "floor of benefits." Under the proposed bill, social security taxes in 1966 for the wage earner making $5,600 per year will be 813 percent

of the original social security tax. Also under that bill, after 1987 wage earners making $6,600 per year will be paying 1,232 percent of the original tax. Of course, their employers will also be paying a like amount in their behalf.

Self-employed persons, who were, of course, not covered by the original law, will be paying 1,186 percent of the original tax starting next year, in 1966. And the proposed law calls for them to pay 1,716 percent of the original tax in 1987 and thereafter.

At the present time, over 5 million American families are paying more in social security taxes than they are paying in Federal income tax. Under the proposed bill, statistics indicate that this figure would climb well beyond 10 million.

Many students of Government have long thought that a social security tax of about 10 percent total for both employee and employer is the maximum our economy can bear. Yet the proposed bill calls for an eventual tax of 11.2 percent—with no guarantee whatever that even this tax will provide the benefits proposed in H.R. 6675.

Looking north across the border gives us a good idea of what can happen to costs in just a short period of time. The following table is from Dr. Sanders' article, referred to above, in the November 1964 issue of Nation's Business:

How hospital costs have climbed under Canada's health program

Provinces	1959	1960	1961	1962	1963	1964
Newfoundland	100	165	178	219	262	305
Prince Edward Island	.....	100	226	309	374	430
Nova Scotia	100	519	610	755	860	965
New Brunswick	.....	100	173	200	238	276
Quebec	.....	.....	100	524	637	817
Ontario	100	547	648	795	929	1,035
Manitoba	100	158	183	213	243	275
Saskatchewan	100	159	171	189	217	253
Alberta	100	179	193	225	294	323
British Columbia	100	160	176	202	235	264

The index of cost at start of plan is 100. Some are blank because not all plans started same year.

French Labor Minister Gilbert Grandval recently reported to President Charles de Gaulle that France's social security system is near the financial breaking point.

England's national health plan has been characterized by ever-increasing disaffection, as we all know so well. Doctors have been leaving the country at the rate of about 500 per year, and recently those remaining were forced to ask for "overtime" in order to maintain their standard of living.

Belgium and Italy have seen doctors strike in order to maintain some semblance of control over their own profession.

Proponents of the "medicare philosophy" state in rebuttal that the proposed bill isn't socialized medicine, that it merely provides selected benefits for one segment of our population. Who among us is willing to wager that once a bill such as this is passed, the pressures from the social planners to turn it into socialized medicine, covering every group of our people, will not be overwhelming?

The third reason we are opposed to the medicare sections of H.R. 6675 is that they will cause overutilization of our hospitals and will result in decreased quality of medical care. Across the country today, many of our hospitals are bursting at the seams, and people needing attention are often forced to wait for admittance due to lack of bed space. This in spite of the fact that we are already building hundreds of new hospitals, and expanding old ones, every year. England, with its national health program, is seeing its hospitals deteriorate at an ever-accelerating rate.

When a minor illness will be paid for out of social security funds if the patient is in the hospital, but must be paid for out of his own funds if he is not hospitalized, the temptation to go to the hospital will be great indeed. This type of utilization is not one that our country can afford. We cannot afford to pay its costs; neither can we afford to divert hospital beds from those who are seriously ill and need them.

Overlong waits for hospital beds, overcrowded hospitals, and the overworked staffs that result will inevitably cause a lowering in the quality of medical care. Medical experts agree that there can be no other outcome.

Because the ramifications of a bill of this type are so far reaching no such bill should be passed until it has been thoroughly explained to the American people, and a majority of them are for it. In 1961 and 1962, 52 Congressmen polled their constituents on the medicare concept. A majority of those replying opposed it in 33 out of the 52 polls. In 1963 there were 23 such polls, and a majority were against in 22—all except 1.

In January of this year a Gallup poll stated that a majority of Americans favor medicare. Yet the fourth paragraph of the story accompanying the poll results showed that beyond a shadow of a doubt 77 percent of Americans didn't even know what was covered in the legislation they were asked about. No bill should be passed until the American people have been educated to both the evils and the virtues of it, and they can make an intelligent decision. The Federal Government, with its vast number of bureaus, could easily undertake this educational process on a nonbiased basis.

Of all the vast changes called for under H.R. 6675, those under section 303, amending the social security disability program, are undoubtedly the most objectionable. This section was apparently added to the bill with no prior planning and with no study made of the vast effects it might have. Lowering disability requirements will decrease individual initiative and increase malingering among the less responsible segment of our population. The experience of our life insurance companies with total disability income during the 1930's, when many people were unable to find suitable work automatically became "disabled," proves that this statement is true.

Section 303 changes the entire concept of the disability insurance section of the social security law. Heretofore, disability under social security has been a form of early retirement for those who were disabled with little or no hope for recovery. Under section 303, social security is invading the short-term disability field to pay benefits to those who are disabled for a shorter period of time and who have every reason to believe they will be able to return to work. In so doing, the Social Security Act is invading a field that is already well covered by private insurance companies.

In addition, this section overlaps the workmen's compensation systems of the various States, which already are set up to pay benefits to workers who suffer short-term disabilities.

The confusion and conflict that such a Federal law will cause in the various States, and the hardship that it will cause to insurance companies and agents who have labored hard to serve this need well should be avoided.

Thank you for allowing our organization to submit this written testimony to your committee to assist you in your deliberations.

We thank you and we would be happy to attempt to answer any questions that you would like to ask about it.

Senator ANDERSON. Thank you for a very fine job of presenting your statement.

You say:

The third reason we are opposed to the medicare sections of H.R. 0675 is that they will cause overutilization of our hospitals and will result in decreased quality of medical care.

The representative of HIP testified a few minutes ago. He has had experience in this field with 700,000 people. Have you statistics to back up what you have said? He has statistics to show what you say is not correct.

Mr. HILL. Senator, my statements are based not so much on actual statistics as they are with actual visits with hospital administrators around the country. We have, for example, in our own State of Indiana—and I am sure this is rather widespread around the country from what hospital administrators have told me—there is a lack of hospital beds at the present time.

We have had in our own city a tremendous expansion in hospitals in the last 5 years. Five years ago we spent $16 million in Indianapolis that was raised privately to expand our hospitals. We are currently embarking on another $15 million program at the present time.

We do not have the—and I think probably I can say Indianapolis is a reasonable and forward-looking city—we do not have enough hospital beds to take care of the people. We are forced to ask them to wait when they are coming in, when they need surgery, a lot of times when they need something that, perhaps, is even more serious. Now, critical people, people who have critical conditions, do get in. There is no question about this, space is made for them. People who would be better off in the hospital cannot get in without a long wait in many instances.

Senator ANDERSON. I am not questioning the fact that we have need for hospital beds, although we have plenty other figures showing that there is an underconsumption across the whole country. But, as you say, it will cause overutilization of hospitals. The HIP organization, with its thousands of people, with no deductibles of any kind, shows that they do not have a sudden rush just because they are covered by insurance.

Do you have any figures showing they do?

Mr. HILL. No, sir; I have no figures to show that they do.

Senator ANDERSON. On section 303 we have a lot of testimony on it, as you well know.

Mr. HILL. Yes, sir.

Senator ANDERSON. And the action of the House was to sort of have a study come in by December 1966. We hope that will be done earlier, and I realize that your figures of how these charges have jumped is probably correct. But, as one who was around here a little bit when the first work was done on the social security bill, it was recognized that the initial premiums were made purposely very small because there would be very few retirement claims.

I think it is sort of straining a point a little bit to point out the fact that they are very small for a brief period when we all know what they were to grow to.

As you well know, the original amount of wage base on which the tax was levied was very low in the initial stages.

Mr. HILL. Right, sir; 1 percent on $3,000.

Senator ANDERSON. To equal that today what would it take? A wage base of $13,000. Nobody is advocating anything like that. So I think you have to look at——

Mr. HILL. This is one of the things about which we are very much concerned. We are not certain that it will not eventually be $31,000, Senator, with a depreciated dollar. I think it very well could be.

Senator ANDERSON. Did you worry about it in the first instance in 1935 when it was very small?

Mr. HILL. I have been worried about it ever since I have been old enough to know anything about social security. I think costs are impossible to predict in this area. I think we have some very efficient people in this area, Mr. Sanders, certainly Mr. Myers, a very, very competent gentleman, who has several times adjusted his own estimates of what these costs are going to be.

I think, Senator, it is true we just do not know. I do not know, and I do not believe anyone knows what the costs will be.

Senator ANDERSON. Well now, when we dealt with disability, it was to be confined only to people who were past 50 years of age. The figures that the Department used were conservative figures. The claims did not come in nearly as fast as there had been prediction that they would and, therefore, the rate was on the liberal side. We collected too much from them.

Then people came in and suggested we take off all age limitations, and Bob Myers predicted that would throw us into a deficit condition, and it did and, therefore, I say their predictions have been pretty accurate. They are better than mine are on baseball games and things of that nature I know.

Mr. HILL. If this bill passes, Senator, do you not anticipate there are many people who are going to come in again next year and ask that this age restriction be taken off again? Isn't this the history of bills of this kind, that we keep removing restrictions and removing restrictions all the time? Can't we say that is a fair statement of social legislaion that this is what happens?

Senator ANDERSON. I think social legislation has been expanding, and probably will continue for a long time.

Mr. HILL. I don't know of any that has ever been repealed. This is the——

Senator ANDERSON. I don't either. That is the very interesting part of it. When I was first in the Congress we would hear Mr. Crawford from Michigan and Bob Rich from Pennsylvania get up and

shriek "Where is the money coming from?" Horrible things. He was for striking it all out.

I haven't heard a Member of either the Senate or House make a speech advocating the repeal of social security in the last 10 years. But I had to wait 20 years to have that happen, and after a few years I don't expect to have any protests on this sort of a program. It is hard to look at, perhaps, but it works out pretty well.

Senator Douglas.

Mr. HILL. Senator, in conclusion, may I ask you a question, please? Is this highly unethical or irregular?

Senator ANDERSON. Well, it is a little irregular, but go ahead.

Mr. HILL. May I have your permission to do so?

Senator ANDERSON. Yes.

Mr. HILL. There is one thing that I wondered about very much, and I have been working in this area a number of years, and that is this: What is wrong with the concept of helping people who need help and not covering people who don't? This is one point I have never been able to get clarified in my own mind.

Senator ANDERSON. Well, the answer is you cannot tell who needs help. In the depression of 1929, 1930, 1931, people we never thought would need help jumped out of high windows and buildings and killed themselves.

Now, I have been in the social security program, not that I think my wife is going to need that help, but she might and, therefore, very wisely the Social Security people in the beginning said "We cover everybody."

The man who knows he is going to have a need and the man who does not, having paid your premiums, you do what you do in any other form of insurance, you collect your dividends.

Mr. HILL. Of course, actually, social security is not comparable to insurance, is it, sir? I mean, the Supreme Court has held on a couple of occasions that it is not insurance.

Senator ANDERSON. Well, they held it is not insurance. But I wonder why it got to the Supreme Court if they did not think there was some similarity.

Mr. HILL. I think that is true. There was something to adjudicate.

Senator ANDERSON. What happened was the life insurance people came down in 1935 and testified about the great dangers of this to the life insurance business. They said that people wouldn't buy life insurance if they knew they were going to have money through social security. And yet when people found out that they did not have to put away money for a rainy day, because that was being taken care of by social security, they bought life insurance in unprecedented quantities, nothing like it ever anticipated, and you are going to see, I am very happy to predict here, that the greatest boom in health insurance that the country has every known will come after the passage of the act. When you have money that you can afford to put into it, people will buy it, and life insurance today is in its greatest condition because regular basic protection is taken care of. They now can put additional sums and tremendous sums into life insurance policies.

Mr. HILL. You bring up life insurance, and I think it is very interesting in regard to this section 303 of the bill. This is one of the things you mentioned, about people jumping out of buildings and so forth,

this is one of the things life insurance companies discovered, as you are well aware back during the depression, this difficulty in the disability field, that people who were not disable became disabled in order to get a monthly check.

Senator ANDERSON. And yet the disability end of it was operated at a profit for many, many years, until it shifted to the removal of the 50-year base, which I opposed then, which I oppose now, and which I would like to see put back. But I am not in the majority.

Mr. HILL. May I thank you again, Senator, and I would like to say if the bill passes, I hope it works out as well as you think it will.

Senator ANDERSON. I only hope it will, too.

Senator DOUGLAS. I want to start off by commending the witness for his candor in giving not merely the arithmetic average of the assets of the people over the age of 65, but also the median.

Mr. HILL. Thank you, sir.

Senator DOUGLAS. And there is a great difference between the two. The figure for the arithmetic average is $30,718. That is derived by dividing the total amount of income by the total number of heads of families. Under this arrangement you could have one man owning $1 million, and 32 owning zero, and the arithmetic average would be $30,000.

Senator ANDERSON. Senator Douglas, you remember the famous example of the fact that only five families living in an area, a certain area, and three of the four of them had less than $1,000 a year, but one man, who was retired down there from New York had an income of over $1 million a year, so they testified that the average income in that area was $200,000.

Senator DOUGLAS. Or one man ate six meals a day, and the second person had no food at all, and the two of them would have an average of three good meals a day, and there would be no suffering whatsoever.

Now, I am glad that you do use the median. I want to commend you for that.

Mr. HILL. Thank you, sir.

Senator DOUGLAS. But notice that the median is $10,000 or in other words, one-half the people have total assets, assuming these figures are correct, of less than $10,000. Now, of that $10,000, what proportion consists of homeownership?

Mr. HILL. I think, sir, you will find a statement of that in the next paragraph where we talk about the debts of older people, and I think it has been proven that their debt load is unusually small.

Senator DOUGLAS. I am not speaking of the debt load, but speaking of assets.

Mr. HILL. Less than one-half of——

Senator DOUGLAS. I would be interested to find out what proportion of the aged people have assets of less than $5,000. I think you will find that the assets of this group almost entirely are in the form either of cash surrender value of life insurance or equity in homes.

Now, are we going to say that if an aged person has an attack of cancer or paralysis or stroke or heart disease so that he cannot work, he has got to put his house up or cash in on his life insurance policy? I don't believe we want that, we are trying to protect homeownership.

Mr. HILL. On this point, Senator Douglas, I thing there are millions of Americans who would like to see a bill exactly like this to decide

for us where exactly the figure will be, and then write a bill where the people should provide help. It it is $5,000, fine, rather than where it ought to be, and I think with all the vast resources we have in our Federal Government, a study could be undertaken to find it out.

Senator DOUGLAS. Your figures show that a very large proportion of the people over 65 are still in need. Some years ago the income of half the couples over the age of 65 was less than $2,500 a year. Probably the figure today would be $2,700 or $2,800, something like that. Half the single men and single women over 65 had incomes of less than $1,000 a year, less than $20 a week.

Mr. HILL. The figure is here, sir, at the top of page 5.

Senator DOUGLAS. What is that?

Mr. HILL. The figure is here, sir, the figure you are just mentioning. That half the Nation's 65 and older families earn less than $2,875. This is a 50-percent point at the present time, sir.

Senator DOUGLAS. Yes.

Mr. HILL. This comes from the Social Security Administration.

Senator DOUGLAS. Now, on this question of hospital costs, have you figures on the increase in hospital costs in the United States in the last few years?

Mr. HILL. They are going up and up and up, no question about it.

Senator DOUGLAS. That is right.

Mr. HILL. Everywhere.

Senator DOUGLAS. We have not had any system of governmental assurance for hospital costs, but they are still going up.

Mr. HILL. Yes, sir.

Senator DOUGLAS. I remember when I was trying to get the administrators at our hospital at the University of Chicago to cut the cost per day below $12. I thought $12 was too high. The average cost now is around $40.

Mr. HILL. Yes, sir.

Senator DOUGLAS. It is still going up. So I do not know that you can charge all of this increase to the fact that there is a big demand for hospital services under the Canadian system or imply that this necessarily will follow if we put in medicare.

Mr. HILL. I think the figures here show that a lot of these though in 6 years have gone up 3 and 4 and 5 and 6 times, and one of them more than 10 times, and I think our costs have not been comparable to that.

Senator DOUGLAS. I wonder if the staff could not supply for the record the exact figures on the increase in the average hospital charges in the United States in recent years.

Senator ANDERSON. Do we have it available? We can put it in. Put it in the record.

Senator DOUGLAS. I would like to have it in the record.

Senator ANDERSON. It went from $9 a day to $40 a day in this period covered by the study.

Senator DOUGLAS. The staff tells me the increase has been at the rate of about 7 percent a year. I would like to have those figures put in the record. Apparently they are in the report on page 50. These are in increments per year, percentage increments per year, but not in absolute dollars. I would like to have the report in dollars put in.

Senator ANDERSON. We have a figure that shows it goes from $9 a few years ago to $40 now—a very steady increase. We have that here.

Senator DOUGLAS. Let us put that in the record.

Senator ANDERSON. It will be put in the record.

Senator DOUGLAS. Thank you very much, Mr. Hill, for a very able report, though it is too gloomy.

(The information referred to follows:)

TRENDS IN HOSPITAL PATIENT-DAY COSTS

Average hospital[1] cost per patient-day

Year	Average cost per patient-day[2]	Percentage increase since—		
		Previous year	1953	1946
1946	$9.39			
1947	11.09	18.1		18.1
1948	13.09	18.0		39.4
1949	14.33	9.5		52.6
1950	15.62	9.0		66.3
1951	16.77	7.4		78.6
1952	18.35	9.4		95.4
1953	19.95	8.7		112.5
1954	21.76	9.1	9.1	131.7
1955	23.12	6.3	15.9	146.2
1956	24.15	4.5	21.1	157.2
1957	26.02	7.7	30.4	177.1
1958	28.17	8.3	41.2	200.0
1959	30.19	7.2	51.3	221.5
1960	32.23	6.8	61.6	243.2
1961	34.98	8.5	75.3	272.5
1962	36.83	5.3	84.6	292.2
1963	38.91	5.6	95.0	314.4

[1] Short term general and special hospitals, excluding psychiatric and tuberculosis hospitals.
[2] Represents the total expense incurred by hospitals per patient-day, and not necessarily the charge to the patient.

NOTE.—These average costs are not uniform throughout the country. They vary by type and size of hospital, by geographical area, and by other factors. This table shows that hospital costs have been rising rapidly, but the rate of rise has been much slower during the last 2 years on record.

Source: Hospitals, Journal of the A.H.A., Guide Issue, pt. 2, Aug. 1, 1964.

Senator DOUGLAS. There is one further point I would like to make. You mentioned a tendency on the part of social security plans to expand covereage, increase benefits, lower the age of eligibility, and so forth, which tend to increase liabilities above the initial estimates.

Mr. HILL. Yes, sir.

Senator DOUGLAS. I think this is true. But there is a safety factor which you did not mention; namely, the fact that average income increases under social security. I am not speaking of the upper limit, but I am speaking of average income, and as the average income increases, the income of the social security fund increases. This has provided a margin of safety which has enabled the improvement in benefits to be granted, and yet for the reserve to be large. I think the last time I looked at it it was $22 billion.

Senator ANDERSON. $22 billion?

Senator DOUGLAS. $22 billion.

Some years ago when we had a very fine Republican who was Under Secretary of Health, Education, and Welfare, Mr. Elliott Richardson, we were considering the expansion of social security. I admired him for insisting to testify, despite the fact they were pulling on his coattails and trying to prevent him from testifying, that, ac-

cording to his estimates, the ultimate social security fund in approximately 50 years, would amount to $150 billion. I honored him for that because it was very frank and honest testimony, and he gave it even though it did not coincide with the wishes of those who were around him. But even in this estimate, he did not take into account this safety factor of the increase in average income. There is that element of safety.

The Department's Chief Actuary, Mr. Myers, has always been very careful in excluding this safety factor. I push him again and again on this, but he will never take it into consideration in making his estimates. Nevertheless, it has always been there, and it is an important factor which has enabled the social security fund to remain solvent and to accumulate its reserves despite the increases in benefits to which you very properly point.

Mr. HILL. I think the thing, Senator, if I may say so, Senator, that concerns us most is the attitude of some of the people very closely involved in writing these bills. For example Under Secretary of Health, Education, and Welfare Cohen a few years ago made the statement that the ideal would be reached when social benefit taxes for every American family were as high as the Federal income taxes. This is something that concerns us very much.

Senator DOUGLAS. Well, I daresay that everyone has made foolish statements at one time or another in his life. [Laughter.]

Mr. HILL. With that I cannot quarrel, sir.

Senator DOUGLAS. The American Medical Association has made foolish statements, and sometimes even private insurance companies have made foolish statements, and I have got some of them in my files, but I do not believe in bringing them out because you have got to allow for a certain degree of exaggeration in the arguments of human beings, a certain gilding of the lily, a certain degree of puffing advertising, so to speak. I believe the law permits puffing advertising.

But I want to assure you that is not the intent of the sponsors of this measure.

Mr. HILL. Thank you, gentlemen.

Senator ANDERSON. Thank you very much. We will meet tomorrow morning at 10 o'clock.

(Whereupon, at 1:10 p.m., the committee adjourned to reconvene at 10 a.m. on Friday, May 14, 1965.)

SOCIAL SECURITY

FRIDAY, MAY 14, 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, Long, Douglas, Williams, and Curtis.

Also present: Elizabeth B. Springer, chief clerk.

Senator ANDERSON. The committee will be in order.

Congressman Emanuel Celler, chairman of the steering committee of the New York delegation, has submitted a written statement for the record in lieu of being here. His statement is being inserted in the record today.

(The statement referred to follows:)

STATEMENT OF CONGRESSMAN EMANUEL CELLER, OF NEW YORK

New York State has been engaged, for the past 2 years, in planning a comprehensive program to meet all the mental health needs of the people through the combined efforts of Federal, State, and local government and with the cooperation of private and voluntary agencies.

As a separate, but coordinated effort of the overall planning, an 86-member committee has been carrying on a statewide mental retardation planning effort since June 1964 under a 1 year, $60,000 grant from the Federal Government. In contrast, mental health planning has gone forward under two annual Federal grants totaling more than $500,000.

Mental retardation affects about 3 percent of the entire population. Based on this premise, it has been estimated that the number of mentally retarded in New York State was 500,000 in 1963 and it is anticipated this will rise to nearly 600,000 in 1975 and 700,000 in 1990. Above and beyond the specialized programs required by some, the goal of both immediate and future planning for these mentally handicapped is a complete and closely interrelated range of services, similar to those provided for other members of society, that will permit them to remain in the community.

As a result of the shorter planning period, however, mental retardation efforts on a comprehensive basis in New York, as well as throughout the Nation, have lagged far behind the mental illness component in the total mental health program. In a State of the size and complexity of New York the task of identifying gaps in existing services and determining future programs is staggering.

While some definitive recommendations will be forthcoming in the initial report of the statewide planning committee, there is a clear need for a number of special in-depth studies which cannot conceivably be carried out in the period for which planning funds are now available. At best, these recommendations will be but a beginning. The challenging task of providing maximum care for these less fortunate State citizens requires a continuation of federally supported planning efforts.

Senator ANDERSON. The first witness is William C. Fitch, American Association of Retired Persons and National Retired Teachers.

Mr. Fitch.

STATEMENT OF WILLIAM C. FITCH, EXECUTIVE DIRECTOR, NATIONAL RETIRED TEACHERS ASSOCIATION, AMERICAN ASSOCIATION OF RETIRED PERSONS; ACCOMPANIED BY ERNEST GIDDINGS, LEGISLATIVE REPRESENTATIVE OF THE ASSOCIATION

Mr. FITCH. Mr. Chairman and distinguished members of the Senate Finance Committee, my name is William C. Fitch. I am the executive director of the National Retired Teachers Association and the American Association of Retired Persons. With me is Mr. Ernest Giddings who is the legislative representative of the associations.

The combined membership of our associations totals almost 1 million individuals 55 years of age or older. The associations are nonprofit, nonpartisan, and are dedicated to promoting age as an achievement, encouraging and creating opportunities for purposeful living throughout the later years, and to maintaining independence and dignity as the right of all citizens, including the 18 million older Americans in our population today.

Our longtime interest in the health and welfare of older persons is documented by the fact that the National Retired Teachers Association pioneered the first health insurance program for persons over 65 that had no age limit, could not be canceled, and required no physical examination.

Our drug-by-mail service has filled over 2 million prescriptions of our members at considerable savings. Our entire service program is designed to assist and encourage older persons to help themselves and each other.

We have favored a national health insurance program and in her testimony before the House Ways and Means Committee in July of 1959, the president and founder of our associations, Dr. Ethel Percy Andrus, urged "the best medical coverage for that portion of our population—men of 65 or over and women 62 or over—which is not eligible for and/or being served by public assistance in its medical care program."

The National Retired Teachers Association and the American Association of Retired Persons have maintained that health insurance legislation adopted by the Congress should take into consideration (1) the dignity and independence of the aged; (2) the hospital, health, and medical needs of all the aged; (3) the valuable experience private companies have gained in the field of health insurance; and (4) the maintenance of the actuarial soundness of the social security program.

Because H.R. 6675 meets most of these aims, I welcome this opportunity to say that our associations are in basic accord with the provisions of the bill and urge early enactment by the Congress.

Our support of the bill does not imply complete accord with all of its provisions, several of which I would like to call to your attention for possible consideration in drafting the final bill.

Under Part B: Supplementary Health Insurance Benefits to the Aged there is established—

a voluntary insurance program to provide health insurance benefits for individuals 65 years of age or over who elect to enroll under such a program to be financed from premium payments by enrollees together with contribution from funds appropriated by the Federal Government.

This section is not understood by most persons and implies a freedom of choice among carriers of private insurance which is not the intent of the bill as presently written.

We would urge that the individual be permitted the opportunity to make a selection of a private insurance carrier from among those approved by the Secretary of Health, Education, and Welfare, similar to the plan now offered to retired civil service employees.

As more of our members become familiar with the details of H.R. 6675, we are being requested to call your attention to that section of the bill which denies them the 3 percent of their adjusted gross income which is permitted as a deductible expense for medical care for income tax purposes. To the elderly who have been able to claim this deduction for medical expenses, this is, and I quote from one of the letters, "giving with one hand and taking it away with the other." We would ask that you review the section on medical expense deduction and eliminate the 3-percent limitation.

It is obvious that a program of such magnitude cannot anticipate all of the details necessary to implement each of the provisions. We are well aware that such items as "utilization review," "reasonable cost," "spell of illness," and many other definitions must be worked out with those who are best informed. To the extent that our associations with their publications, responsible local units and chapters throughout the Nation and almost 1 million articulate members can be helpful in rendering a national service in the implementation of this legislation, we are prepared.

It is not my intention to refer to Title III: Social Security Amendments as a postscript to this testimony on H.R. 6675. We are aware that several of our proposals have long-range significance. We are deeply concerned that certain provisions of this legislation do not take into consideration all of the relevant facts which are necessary to produce legislation which will effectively mitigate the social and economic problems with which this legislation is concerned. We believe that certain provisions in this legislation only partially deal with problems of vital importance to the Nation's older citizens.

H.R. 6675 provides for a basic benefit of $35 for certain persons age 72 or over who have a minimum of three quarters of coverage.

At present there are about 1.5 million persons age 72 or over who are excluded from social security benefits primarily because their working life was completed, or substantially completed, before social security coverage was extended to their former work. Many of these people have less than six quarters of coverage. Many have no quarters of coverage. Most of these people have not qualified and will not be able to qualify for social security because, after social security coverage was extended to their former work, they have been unable and are unable to work long enough to acquire the necessary quarters of coverage.

Death will eliminate this discrimination if the Congress does not. We believe that a more just, equitable, and a more American way to deal with this problem is for Congress to act now to provide social security coverage for these people.

This legislation is laudable in that it apparently recognizes most of these facts, but it can be criticized in that it fails to go as far as the facts indicate it should.

Persons 72 or over with a minimum of three quarters of coverage should be given social security benefits, as this legislation provides, because of their past and present limited opportunity to get the now required six quarters of coverage, and because some of these people have contributed as much as, or more than, persons now receiving benefits. But we also believe that those persons, with three or less or no quarters of coverage who also had a limited or no opportunity to achieve an insured status, should also be given a similar benefit. There seems to be only a partial recognition of the pertinent facts when it is realized that this legislation gives a basic benefit to those who had a limited opportunity to achieve an insured social security status while those who had or have no opportunity at all to achieve an insured status get nothing.

Logically, it would seem that all persons who have been discriminated against, inadvertently or not, should be entitled to the basic benefit granted by this legislation.

Congress has already recognized a certain responsibility to these persons by the approval of the House this year and the Senate last year of a health program for all persons 65 or over. A complete fulfillment of this responsibility can be attained by legislation which would provide benefits for all persons 72 or over. For many of these persons 72 or over, such legislation would mean receiving an income with dignity and self-respect rather than receiving an income with a welfare stigma.

Estimates prepared by the Social Security Administration, Division of the Actuary, reveal that legislation which would grant a benefit of $42 a month to all persons 72 or over in a "transitional" or eventual "washing-out" basis and which would be financed by transfers from the general funds of the Treasury is actuarially feasible. This proposal, which is essentially the legislation proposed by Congressman John W. Byrnes in 1964, has been condensed and put into table form by our staff. This table can be found on the last page of this testimony for inclusion in the record.

Congress would not be without precedent if all persons 72 or over would be granted a basic benefit. When the Railroad Retirement Act was passed in 1935, it included all retired railway workers within its provisions for immediate benefits and the then current employees and employers carried the necessary cost.

Taking all of the facts and equities into consideration, it seems unjust that the legislation before this committee does not make more comprehensive provision for all persons 72 or over who are not now eligible for social security benefits. More comprehensive legislation would give a more just and equal treatment to a deserving group of older citizens who have struggled, and who are struggling, to maintain their independence and dignity during a period of rising living costs.

H.R. 6675 provides a 7-percent across-the-board benefit increase effective retroactively beginning January 1965, a minimum increase of $4 for retired workers at age 65.

From the many letters we receive, our members are all too aware that the last adjustment in social security benefits was enacted in 1958. NRTA and AARP are also aware that, taking all facts into consideration, the benefit increase proposed in H.R. 6675 appears to be minimal.

Since the last benefit increase, the cost of living index has risen 9 percent. The cost of medical care has increased by 20 percent.

Since the hospital and health insurance provisions of H.R. 6675 do not cover drugs except those covered under the basic health insurance plan, OASDI beneficiaries will continue to bear the burden of increasing drug costs. Since the aged spend more on drugs than other persons, it should be realized that even the 9-percent increase in all prices is not a good standard to use for the determination of an appropriate increase in social security benefits.

The Advisory Council on Social Security has made a proposal for a benefit increase that would average about 15 percent which would take into consideration past price and wage increases. Because of the increase in the cost of living since this proposal was made, even this proposed benefit increase would have to be increased from 15 to 17 percent.

This proposal seems very feasible and we respectfully urge the committee to give it the consideration it deserves.

Taking into consideration the above facts, and the usual interim period of 4 to 6 years between OASDI benefit adjustments in the program, a 10-percent across-the-board increase with a minimum increase of $6 seems more realistic and would be considerably more just and meaningful to the older American living on social security income.

H.R. 6675 liberalizes the earnings limitation in the social security law by providing for a $1 reduction in benefits for each $2 of earnings between $1,200 and $2,400.

Benefits would be reduced $1 for every $1 of earnings above $2,400.

NRTA and AARP believe that both the present and proposed earnings limitations place too many restrictions on the older citizen receiving OASDI benefits. This conclusion is supported from the letters we receive from our members.

Persons receiving minimum yearly benefits of $480 under present law can only earn $1,200 which gives them a yearly combined income of $1,680 without a reduction in benefits. Under the proposed benefit increase, a person receiving minimum yearly benefits could have a combined earned and social security income of $1,728 without a reduction in benefits. According to the latest "poverty level" estimates, these persons are about $200 above the poverty line for individuals, but this does not mean that these persons have an adequate income when it is realized that 1 out of 3 persons 65 or over is supporting an aged relative who may or may not have an income. Nor does it mean that OASDI beneficiaries have an income that will enable them to maintain their dignity and self-respect. The "dignity and independence level," if we may also coin a phrase, for the older citizen is a factor to be considered apart from the so-called poverty level.

Furthermore, the extent of the present discrimination against earned income is unjust as it places too high a penalty on the independence of the older citizen. It seems unfair that a person who is forced to work to supplement his social security income should be penalized to the extent he is under present law, while those persons receiving an interest, dividend, or rental income, are not.

Furthermore, under the present or proposed earnings limitation, the older citizen has or would have little incentive to contribute to the national economy as well as to make a more satisfying life of productivity for himself.

We are aware that the earnings limitation might be necessary for a retirement system that is supposed to replace earned income. Even if this is so, this consideration must yield at least a little when overriding inequities arise. For this reason, we feel that this rationale of replacing lost earned income must yield when it is realized that the rationale (1) is preventing certain persons from attaining a level of income necessary for an adequate standard of living; (2) is preventing certain persons from performing necessary and productive work; (3) is causing an unnecessary discrimination against a type of income; and (4) is unfair because lost income is not adequately replaced by social security income.

Taking all of these factors into consideration, NRTA and AARP feel that increasing the earnings limitation to permit earnings up to $1,500 without a reduction in benefits would be reasonable and just.

H.R. 6675 provides for the payment or the continued payment of benefiits to the divorced aged woman on the basis of her former husband's earnings if certain conditions have been met. H.R. 6675 further provides that a woman whose rights to benefits as a widow, divorced wife, surviving divorced wife, or surviving divorced mother were terminated because she remarried, will have her former benefit rights restored if her second marriage ends in divorce after less than 20 years. These provisions are laudable, but they do not go as far as logic and other considerations compel.

As it is not uncommon for a marriage to end in divorce after many years, when the wife is too old to build a substantial earnings record, it has become necessary to make provision for the aged divorced woman comparable to the provisions in present law that permit a widow to receive widow's benefits upon the death of her husband. H.R. 6675 makes this provision, but like present law, it does not take into consideration the financial plight of the divorced woman and the aged widow who contemplate remarriage.

H.R. 6675 and the present law place a restriction upon the remarriage of the aged divorced woman and aged widow by providing that a divorced woman or widow cannot continue to receive benefits on their former husbands' earning record if they remarry.

Present law and H.R. 6675 force and would force many elderly couples into socially undesirable relationships because in many cases the aged divorced woman and aged widow and their prospective husbands cannot and could not afford to live on the income they would have if they remarry or remarried, since the widow or the divorced woman would lose her social security benefits.

A more desirable solution to this problem would be legislation that would enable the aged divorced woman or aged widow to continue to receive benefits based upon her former husband's earning record if upon her remarriage she is not entitled to comparable benefits based upon her husband's earning record. Legislation of this type would permit elderly couples to marry and to retain their past standard of living rather than forcing them into socially and economically undesirable living situations.

(The proposal referred to follows:)

Blanketing in proposal[2]

Quarters of coverage required, if any			Benefit disbursements		Reimbursement from general revenues[3]	
Quarters required for benefit (men)	If age 72 is attained in—	Quarters required for benefit (women)	Amount	Year	Amount	Year
			Millions			*Millions*
0	1966	0	$730	1966	1966	$825
0	1967	0	590	1970	1967	50
6	1968	6	280	1975	1968	50
8	1969	(1)	90	1980	1969	50
10	1970	(1)	25	1985	1970	50
12	1971	(1)	5	1990	1971	50
(1)	1972	(1)			1972	0

[1] Figures based on memorandum prepared by Social Security Administration, Division of the Actuary, 1964.

[2] Proposal would be partially financed by transfers from the general funds of the Treasury to the OASDI trust fund of an amount for each beneficiary under the proposal equal to the total of the combined employer-employee contributions, plus accumulated interest at 3 percent, that would have been payable from Jan. 1, 1961, through Dec. 1, 1965—or if later, up to the beginning of the year in which the beneficiary attained age 72—as though the individual had been covered under OASDI throughout the period at a level of monthly wages of $67 (largest average monthly wage that will produce a benefit of $42 a month). The balance of the cost of these blanketing in payments would be absorbed in the general financing of the system.

[3] Same as now required by law.

Senator LONG (presiding). Let me say I agree with you we ought to have some increase in this earnings limitation.

Senator Douglas has been a big advocate of that and also Senator Anderson has joined me in advocating that.

And I hope we will be able to do something.

Mr. FITCH. Only one other item, this must have been an oversight, that is when this denies the widow who remarries the right to continue her social security benefits.

Senator ANDERSON. Do you think it was an oversight when they discussed it for about 2 days?

Mr. FITCH. Well, we see it from another angle. From the older persons point of view when their combined income, when they marry, doesn't provide a standard of living so they can continue to live decently—at least we have been told—we are encouraging a social condition that probably isn't desirable and so we think this ought to be looked into in terms of what the combined income might be before we decide to——

Senator LONG. Do you think we are discouraging remarriage?

Mr. FITCH. I don't know whether we are discouraging it but we are encouraging other combinations.

Senator LONG. I see.

We will take a look at it.

Senator ANDERSON. There is a quotation that it is always to woo and never to wed.

Mr. FITCH. As a matter of fact, they have developed a ceremony they say for some of the groups in Florida which they call a form of ceremony for living together, and this is with the understanding that if the social security law changes they will go to the justice of the peace and take care of the arrangement.

[Laughter.]

Senator LONG. Make it official.

Mr. FITCH. That is right. Make it official.

We do appreciate having the opportunity to come before you and if I might summarize what I think is the most important part——

Senator LONG. Let me ask you, is that actually the case in Florida, do they have such a ceremony in Florida?

Mr. FITCH. I am not sure. I have a page here that tells the procedure that might be followed. I might include it in the record.

Senator LONG. What I have in mind is that I may have the burden one of these days of debating against the McCarthy amendment which undertakes to say that all single people over the age of 35 are to be treated as heads of household for tax purposes which means they would be treated as though they could split their income with a person who doesn't exist, and that would tend to discourage marriage, and I would like to have that form available just to use it in that particular debate as well as this one.

Mr. FITCH. Right.

(The material referred to follows:)

THE FORM OF SOLEMNIZATION OF LIVING-TOGETHER

PEN-ULTIMATE

At the day and time appointed for Solemnization of Living-Together, the Persons to live-together shall come into the Living-Together Service Center with their friends and neighbours; and there standing together, the Man on the right hand, and the Woman on the left, the Senior Citizens' Service Center Senior Member shall say:

Dearly beloved, we are gathered together here in the sight of these witnesses and out of the sight of the Social Security administrators, to permit the live-together of this Man and this Woman in a relatively honourable estate, instituted by Florida Senior Citizens, signifying the practical exigencies of life betwixt and between the Social Security checks and the understandable desire for human companionship: which estate has been honoured by the long tradition of Common Law and is to be held honourable among all: and therefore is not by any to be approached lightly. Into this estate these two persons present come now to be regularized. If any man, other than a government employee, can show just cause why they may not undertake to live-together, let him now speak, or else hereafter for ever hold his peace.

And also speaking unto the Persons who are to begin living-together, he shall say:

I require and charge you both, that if the Social Security laws are changed to permit the woman to receive her share of her monthly income as widow's benefit despite her remarriage in the eventide of life, ye will present the Certificate for Living-Together at the County Clerk's office in exchange for a Marriage License and will then report to a Justice of the Peace or a Minister of the Gospel to be joined in Holy Matrimony.

He shall then say to the Man:

(Name.) Wilt thou have this Woman to be thy living-together partner, to live-together after the manner of our agreement this day, in the estate of living-togetherness? Wilt thou love her, comfort her, honour, and keep her in sickness and in health until legislation is passed which would permit you to marry?

The Man shall answer:

I will.

Then shall the Senior Member say unto the Woman:

(Name.) Wilt thou have this Man to be thy living-together partner, to live-together after the manner of your agreement this day, in the estate of living-togetherness? Wilt thou love him, comfort him, honour, and keep him in sickness and in health, and wilt thou share thy Social Security Widow's Benefits with him until that day when ye can share such benefits in holy wedlock?

The Woman shall answer:

I will.

Then shall the Senior Member say:

Who endorseth this action?

Then shall all Senior Citizens say:

We.

Then shall the Man and the Woman exchange keys to each other's Safety Deposit Boxes. Then the Senior Member shall say:

I now announce that you may begin living-together, with all right and privileges attendant thereto, including the right to lobby for change in Social Security legislation and the right to continue criticizing the adjustability and flexibility of moral standards in the Younger Generation. Now let us cut the cake.

Senator LONG. Senator Anderson?

Senator ANDERSON. You used one phrase that bothers me a little bit. You say that if they granted $42 a month for all persons 72 or over on a transitional or a washout basis, if it would be financed from general funds from the Treasury it would be actuarially feasible.

What do you mean by that, "actuarially feasible," I thought that meant you had income and outgo and they balanced.

Mr. FITCH. According to the way it was developed, the amount of money involved in this over the long period of time would actually cancel itself out—the amount of money being given to these individuals at the present time. I think it may take away from welfare payments they are getting. It may balance it out in a different account here. But actually not much more money would be involved in making it available this way than they are now receiving through the welfare programs.

Senator ANDERSON. I understand eventually it might disappear but you say "actuarially feasible."

Mr. FITCH. Well, this is the phrase we are quoting from those who have indicated that, while they may be getting it under welfare at the present time, if they were receiving this as blanketing in under a social security program probably would not cost any more, or as much, because you wouldn't have the additional administrative costs and that, probably, actuarially it is not more expensive.

Senator ANDERSON. You want to raise the amount of earnings from $1,200 to $2,400?

Mr. FITCH. We are indicating $1,500 without any deduction and $1 without every $2, so they would be able to earn up to what has been called the $3,000 poverty level. We think that since $3,000 had been decided as the poverty line any time we withhold money from an individual who has the incentive to work after 65, any time the combined earnings with their social security is less than $3,000 we think we are not being inconsistent with $3,000 as the poverty line.

We think they should be able to combine their earnings with their social security up to the amount of $3,000 before any deductions are made.

Senator DOUGLAS. But $3,000 is a poverty level for a family, not for a single person.

Mr. FITCH. That is right.

Senator ANDERSON. Isn't this available to people still working? It would cost a very substantial amount of money and probably would tend to cut down on other people's benefits. This is primarily for people still working, isn't it?

Mr. FITCH. No. We found from our members that this earnings limitation is a real handicap to any acceptance of a job after 65. You know that sometimes the job opportunities are very limited for older persons, but also the earnings limitation very often is the thing that has deprived them of the job opportunity.

Senator ANDERSON. That is all.

Senator LONG. I want to ask you about one or two things in your statement.

You indicated that there had been a 9-percent increase in the cost of living but actually medical expenses are a substantial part of the budget of an aged person, on the average, and in view of the fact that we are providing in this bill a major amount of medical assistance for the aged persons, doesn't this bill actually amount to more than a 9-percent increase in social security benefits?

Mr. FITCH. This was the question I was raising along the way as we were talking about some of the percentages that have been discussed, 7, 9, even 15, 17 percent. I think perhaps to the extent that the medicare program or the health insurance program could be measured in terms of percentage there could be a proportional decrease in the amount of the overall increase.

But I think this was not taken into consideration at the time these other percentages were arrived at.

Senator LONG. Now, that is all.

Senator Douglas?

Senator DOUGLAS. No questions.

Senator LONG. Thank you very much.

Mr. FITCH. Thank you very much. I appreciate this opportunity.

Senator LONG. The next witness will be Mr. Charles I. Schottland, of the American Public Welfare Association.

Mr. Schottland, we are happy to see you here today. I can recall the days when you worked with this committee as the Commissioner of Social Security in helping us to write public welfare and social security law and we are happy to have you before us today.

STATEMENT OF CHARLES I. SCHOTTLAND, REPRESENTING THE COMMITTEE ON PUBLIC WELFARE POLICY OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. SCHOTTLAND. Thank you, Mr. Chairman.

It is a pleasure to be here, and to be with this committee again. I have had the opportunity of testifying before this committee for over 30 years now in my various capacities as director of the State department of California as well as Commissioner of Social Security.

Senator LONG. That would qualify you as a witness. The question is do you have anything new to add to what you told us in the last 30 years?

[Laughter.]

Senator DOUGLAS. I would like to say to my colleague what Dr. Samuel Johnson said once: "Men need not so much to be informed as to be reminded."

Mr. SCHOTTLAND. With me is Mr. Guy Justis, director of the American Public Welfare Association.

Mr. Chairman, and members of the committee, my name is Charles I. Schottland. As a member of the Committee on Public Welfare Policy of the American Public Welfare Association, I am representing that organization here today. I am dean of the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University.

From 1954 through 1958, I was Commissioner of Social Security in the Department of Health, Education, and Welfare. Prior to that, I was the director of the California State Department of Social Welfare. I have been engaged in social welfare programs involving medical care since 1927—in State, local, and private, as well as Federal, programs. My experience has not been confined to administrative work in a home office remote from the people being served. I have handled many an individual case and dealt face-to-face with people in need of help.

Over the years I have had firsthand acquaintance with the problems older people face in meeting the mounting costs of health care. The subject of your hearings is, therefore, of special interest to me personally, as well as the organization I represent.

The American Public Welfare Association is the national organization of State and local public welfare departments and of individuals engaged in public welfare at all levels of government. Its membership includes Federal, State, and local welfare administrators, welfare workers, and board members from every jurisdiction.

On the basis of discussions and recommendations in our councils, committees, and the conferences we hold throughout the country, the association's board of directors, which represents all parts of the country, adopts official policy positions on issues of current significance. These policy positions govern the association's testimony on proposed legislation relevant to the field of public welfare.

I think it is worth emphasizing that the membership of the association consists mainly of people whose daily work involves welfare programs, including public assistance medical care and medical assistance for the aged—Kerr-Mills—programs. These people, whose experience qualifies them to assess the strengths and weaknesses of public assistance, are largely agreed that social insurance—not assistance—should be the first line of defense against not only the loss of earned income, but the financial consequences of serious illness in old age.

In the past 30 years your committee has brought forth a progression of amendments to the Social Security Act which have greatly expanded and improved the social insurance, public assistance, and maternal and child welfare programs. In almost every instance these measures have had the concurrence and support of the American Public Welfare Association, and we are pleased, once again, to express our appreciation to you and your committee for these achievements.

The bill now before you, H.R. 6675, is the most significant and far reaching social security measure to come before you since the act was first adopted. I am pleased to express our general agreement with the major features of this bill. We have a long record of support for a program of hospital insurance for the aged through social security, which we have expressed to your committee on previous occasions. I shall therefore offer only limited comments today on that feature of the bill, and devote the greater part of my statement to the proposed amendments which would more directly affect the programs of the public welfare agencies.

With respect to hospital insurance for the aged, my testimony of last year before the Committee on Ways and Means included the following statement, which summarizes our general position:

> We have drawn upon the experience of the men and women in the ranks of public welfare who administer the medical care programs under public assist-

ance and the medical assistance for the aged program under the Kerr-Mills legislation. These persons are keenly aware both of the need of the aged for medical care and the problems of administering medical care programs. There is wide agreement among them, based on firsthand experience in these programs, that public assistance—valuable and necessary as it is—should not be relied on as the basic public program to cover the high cost of hospital and related care that aged people are not able to meet by themselves.

It is because we have observed so closely and worked so continuously with the administrators of public welfare medical care programs that we feel the association is qualified to conclude that the public assistance approach to meeting the medical care needs of the aged is not the total answer to this question. On the basis of this background of experience and concern, the association by action of its board of directors has taken a position in support of a program for the payment of hospital and related costs of aged persons, to be financed through the OASDI system for covered beneficiaries, and from the general revenue for those who are uninsured.

This year our board of directors has again reaffirmed that position. While we strongly support the hospital insurance measure, however, I must register our disagreement with the proposal for charging a deductible amount to the beneficiary. We are aware that deductibles are supposed to allow for the financing of an otherwise broader benefit package, and to discourage overutilization.

However, we are opposed to deductibles because they create a barrier to early hospitalization for a group of persons for whom early care is essential. Such care, if deferred, could well result in prolonged hospitalization when the patient is finally admitted in an advanced state of illness.

We realize that elimination of the deductible would probably be accompanied by a reduction in the maximum days of covered hospitalization. However, if such a choice had to be made, we would still favor the payment of hospital costs beginning with the first dollar.

The number of people who would require hospitalization beyond the covered period would be comparatively small and some of these would exhaust their benefits whether the limit were set at 60 days or even higher. It is probably not feasible, at least on the basis of current experience, to extend hospitalization under this system to cover the very long term catastrophic illnesses. Some of these cases would ultimately have to be carried on the medical assistance program, which the States could do under the proposed title XIX.

On the other hand, by eliminating the deductible, a much larger number of people would be beneficial, none of whom would have to apply for assistance to pay the deductible, and the administration of the insurance and the welfare programs, as well as the collection procedures of hospitals, would be simplified.

On the basis of the experience of public welfare agencies in paying for hospital and health care services we believe that the charges for the services of radiologists, anesthesiologists, pathologists, and physiatrists, should be included under the hospital insurance plan. These are essentially a part of hospital services, and are usually included in the hospital bill.

Without this coverage in the basic hospital insurance plan, it would mean that for all recipients of assistance, at least some of these costs would have to be picked up by the public welfare agency. Even though these payments would be relatively small, they would require the same procedures as for other kinds of payments, and would add administrative complications out of proportion to the costs involved.

The proposed voluntary supplemental health insurance plan is a matter of great interest to the association. The provision whereby States could buy into the system to cover recipients of old-age assistance would materially affect the costs and coverage of medical care for that group. It would enable some States to provide a level of health services that is not now attainable to them. We recognize that there are a number of new administrative and fiscal relations that would be established which perhaps can only be fully understood through experience. Unfortunately it has not been possible for the association to develop a formal position with respect to this plan in the short time since it was incorporated in the bill. However, on the basis of such discussions as we have had we have received expressions of support for this measure, and know of no opposition on the part of our membership.

The new title XIX of the Social Security Act which would be established by this bill would encourage and enable the States to achieve far-reaching improvements in the public assistance medical care programs. These improvements would be in the direction of more adequate and comprehensive coverage; greater equity among the different groups of recipients; and greater opportunity for administrative simplification.

Some of the Federal legislative improvements in the past have had the incidental effect of adding administrative complexities. The present array of categories, with different matching formulas and eligibility conditions, is a source of real concern to those having responsibility for their administration. We acknowledge that some of these requirements are established by the States, but nevertheless the basic pattern is set by the Federal statute. In any case, any steps that could be taken toward simplification would not only free the agencies to direct their energies into more productive channels, but would also make it much easier for the general public to understand these programs.

The proposed unification of all medical assistance under the new title XIX would be the greatest single step toward simplification that has been taken since the basic statute was enacted 30 years ago.

In addition there would be the specific requirement that States would have to—

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 recipients.

While we welcome the potentialities for administrative simplification that would be offered by this measure, of even greater importance would be the opportunities for States to provide more adequately for the medical needs of those who receive public assistance, and for others who are unable to pay for their medical care. We especially endorse the requirement that medical care would have to be made available in the same amount, scope, and duration for all persons receiving money payments under any of the public assistance categories.

At present these factors are individually established by States for each category, with a resulting unevenness which too often works to the disadvantage of children in AFDC families.

Similarly, the opportunity for States to extend medical care to medically needy persons who, if in financial need, would be eligible for assistance, would bring the benefits of the MAA (Kerr-Mills) type coverage to this wider group. And, again, the requirement for uniformity in amount, scope, and duration, would carry an assurance of equity which would be to the advantage of many children in low-income families.

We also emphasize the importance, as provided for in this bill, of placing administrative responsibility for medical assistance in the same agencies, both State and local, that have had the experience of administering the vendor-payment programs since they were first authorized 15 years ago.

A program of medical assistance, if maintained at an adequate level, may become one of the major items of cost in the public assistance expenditures of a State. Yet it is of the utmost importance that good coverage and high quality of medical services be available to public assistance recipients and other needy persons. States that are currently maintaining such programs should not be penalized, but in all probability should be helped to improve even further, and other States should be given every encouragement to move toward adequacy. The separation of medical costs from the money payment grant formula, and the removal of Federal matching ceilings, as provided for in this bill, are essential steps in underpinning the development and maintenance of sound State medical assistance programs.

Significant as these improvements would be, however, many persons in genuine need for medical assistance would still not be covered under the new plan, nor are they covered under the existing programs. These are persons who, regardless of the extent of their need, would not be able to meet the other eligibility requirements of one of the public assistance categories. They are those who have not reached age 65, who are not blind or permanently and totally disabled, and who, though they may have minor children, are not eligible for AFDC.

For example, a large family with young children, in which the father is employed at low wages, might well be living below the poverty line, and would urgently need medical assistance in case of illness. But under the present proposal they could not be covered because this family, regardless of its need, could not qualify for AFDC.

Or a married couple, aged 60, in which the husband is unemployed, would not be eligible for medical assistance under this program, or under any of the other programs which would be established by this bill.

We recommend that States be given the option of including coverage in their plans for medically needy persons who do not happen to meet the special requirements for classification under any of the public assistance categories.

There are some States, but very few, which now provide comprehensive care for this group from their own funds. Most States provide less in the way of medical care, and some none at all, for this group.

Under the present bill a State could, under new title XIX, elect to provide medical assistance for persons receiving money payments through one of the public assistance categories. If it covers this group, it could then further elect to include medically needy persons not receiving money payments, but who meet all of the other ligibility requirements under one of the categories. Our recommendation is

that a State that has extended coverage to these two groups be given the option of going still another step to include medically needy persons who do not have the tie-in with a category, but who meet the same test of need.

As the bill now stands, a State covering the medically needy group would have to investigate and determine whether an applicant meets the eligibility requirements, except for need for financial assistance, under one of the public assistance categories. This procedure would have to be gone through despite the fact that the persons is not even applying for assistance through any of the public assistance categories. All he wants is medical assistance through title XIX.

It is our view that the only test should be on his need for medical assistance, and not on a number of irrelevant factors. If a State were to include medical assistance coverage for all medically needy persons, no such determination for categorical eligibility would have to be made, because a person would only have to meet the test of need to be found eligible. Therefore, in addition to the other advantages, this inclusion would be still another step in the direction of simplification.

We should like to express some reservation with respect to the proposed requirements for financing of the non-Federal share of medical assistance expenditure. As presently drafted the bill provides that initially no less than 40 percent of these costs would have to be paid from State funds, and by 1970 no local funds whatever could be used. The requirement of 40 percent of State funds in the non-Federal share would present no problem, since, to the best of our knowledge, no State would have to make any new arrangements in order to comply. In some States, however, a great deal of internal rearranging would be needed in order to eliminate all local financial participation.

The House Committee on Ways and Means reports that:

> This provision was included to make certain that lack of availability of local funds for financing of any parts of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State.

We are in agreement that safeguards are needed to assure that the "amount, scope, and duration of benefits and the level of administration set by the States" are adequately maintained. But we have some doubt as to whether the elimination of local financial participation is the key factor in accomplishing this objective.

The real concern, in our view, is not State or local financing, but the quality and coverage of services. We believe it would be better to approach the matter directly, by enabling the Secretary to set high standards for public assistance medical care programs.

The States could then decide for themselves how they would pay for their share of the costs. In any case the prohibition against local financial participation would not become mandatory until 1970. In the meantime the association will give further study to the implications of this proposal, and we may have additional recommendations to make before that date.

We are pleased that the bill includes the requirement that a State would have to show continuing progress toward broadening the scope of care and services and liberalizing the eligibility requirements for medical assistance with the goal of providing comprehensive care and services for all eligible persons by 1975. This provision would call upon States to begin now for an orderly and planned development of

a program that would provide adequate health services of good quality for needy persons.

The requirement for utilization of professional medical personnel by welfare agencies in the administration of the program would be another factor in moving toward good quality and efficient utilization of services. The general shortage of professional personnel qualified for these positions, however, will be a limiting factor in the realization of the full potential of any measure of this kind which Congress might enact. We therefore recommend that specific provision be made for Federal participation at 75 percent of the cost for the training of such personnel in health, medical social service, and related professions needed for the effective administration of the medical assistance program.

The limitation upon the extent to which relatives could be held responsible for health services of an individual is a progressive step which would make medical assistance more readily available to persons in genuine need, and it would relieve the welfare agencies from having to go through a series of expensive, time-consuming, and often pointless procedures.

The prohibition against durational residence requirements has long had the endorsement of the association, not only for medical care, but for all public welfare programs. We are not aware that this prohibition in the Kerr-Mills program has resulted in any movement of persons from one State to the other to take advantage of these benefits.

On the other hand, it has enabled States to provide care for some who were in genuine need, and for whom some arrangements would have been made in any case.

Administratively, one of the drawbacks of residence restrictions is that the verification procedure has to be gone through in every case, even though there are very few who do not meet the test.

In brief, it is the view of this association that the new title XIX would enable the States to take the greatest single step forward in the improvement of public assistance medical care since vendor payments were first authorized in 1950. We support its enactment, and also urge the adoption of the changes we have proposed, especially for extending care to all needy persons, in order to perfect even further this essential and basic public welfare program.

We strongly endorse the increased authorization for grants to States for maternal and child health and crippled children's services as proposed in the bill. These programs have long ago established their worthwhileness and effectiveness. However, a great deal remains to be done to provide preventative and corrective services for many children, especially those from low-income and deprived families.

We also recommend the inclusion in this bill of authorization to increase grants to States for child welfare services in the same amounts as for these other two programs. These three authorizations are parallel and in a sense complementary parts of title V of the Social Security Act, and the need for funds for child welfare services is no less urgent than for the other two programs. We further recommend the elimination of the special provision for the earmarking of a part of the child welfare services funds for use by the States for day-care services.

The development of adequate services for the day care of children is a most pressing task, and the public welfare agencies need all the

encouragement and support they can get to carry forward their part of this responsibility. However, the earmarking feature has now served its purpose of initiating State action and at the same time it has been found to be somewhat cumbersome to handle. We therefore believe that it would be advisable to drop this requirement. We suggest alternative language to the effect that States be required to commit a portion of these funds for the development and support of day-care services.

We endorse the proposal for training professional personnel for the care of crippled children, particularly mentally retarded children and those with multiple handicaps. If persons qualified in the various professional specialties in the fields of health and welfare do not become more readily available, all of our other efforts will be severely limited in their effectiveness. This is indeed a critical need that must be met without delay.

The special project grants for school and preschool children would provide a range of services for groups of deprived children which they would not otherwise receive and which are essential for their sound development into self-supporting and productive citizens. It is expected that such projects would also develop techniques and information that would result in greater effectiveness in extending essential services to this group of children.

We are in general agreement with the proposals for amending the old-age, survivors, and disability insurance program. We recognize, however, that the increase in benefits would do little more than keep up with recent increases in living costs. It is therefore our hope that ways will be found to make a further upward adjustment in the level of benefits.

The proposed increase in the Federal share of public assistance, together with the costs for hospitalization and other health services for the aged that would be picked up by the two new insurance plans, would free substantial sums of State funds that are needed for the improvement of other aspects of the public welfare program. There is the further requirement that the additional Federal funds authorized by this bill would be made available only to the extent that they would be used in the program, and to the extent that existing State expenditures are maintained.

Moreover, Federal funds to a State would be increased only to the extent that total program expenditures would be increased in comparison to a selected base period in 1964 or 1965.

All of these features would combine to enable the States to increase assistance payments to recipients and otherwise to improve the program. The low level of assistance payments in some States is a matter of grave concern to the association. It is our hope and expectation that the provisions of this bill would result in substantial improvements in this respect.

The proposal for extending Federal financial participation to the payment of assistance to aged persons in mental and tuberculosis hospitals carries a number of carefully drawn conditions, designed to improve State services. Special attention would have to be given to the individual circumstances of each of these recipients to assure that they are being given the best possible care, and that alternatives to institutional care be arranged when that is in the best interest of the recipient. The increased Federal participation resulting from these

payments would be used to improve the overall mental health services of the State.

We recommend that further steps be taken to improve the special arrangements for Federal participation in the welfare programs for Puerto Rico the Virgin Islands, and Guam. While these jurisdictions would gain some new advantage in the present provisions of H.R. 6675, the amount is small in relation to the need.

We concur in the proposed option to States to increase the level of income which may be disregarded in determining need for old-age assistance. However, we should like to see a similar option allowed for recipients of aid to families with dependent children. Surely the encouragement of initiative and self-help is just as important, if not more so, for children and their parents as it is for the retired generation.

We endorse the proposed provision for judicial review of administrative determinations by the Secretary which affect State public assistance plans. This does not carry the implication that the present Secretary or the staff of the Department of Health, Education, and Welfare, are arbitrary or capricious, or unduly slow in taking action on matters affecting State interests. Nor is it a condemnation of past actions. The experience of the States in dealing with the Department have been satisfactory, and reasonable solutions have been found to differences that have arisen. The position of the association, however, is that the provision for judicial review is sound in principle, and that it is available to States in other grant-in-aid programs and should not be denied in this one.

In conclusion, Mr. Chairman, I am pleased to express the support of the American Public Welfare Association for the major provisions of H.R. 6675. We also believe the bill could be further improved with a few modifications. With respect to hospital insurance for the aged, we recommend that the services of radiologists, anesthesiologists, pathologists, and physiatrists be covered, and that the deductibles be eliminated. With respect to the medical assistance amendments, we recommend that States be given the option of extending medical assistance to all persons who meet the test of need; and we suggest that the objective of improving the coverage and quality of medical assistance might be more readily attained through the establishment of Federal standards than through a prohibition against local financial participation. With respect to the child health amendments we recommend that the authorization for grants to States for child welfare services be increased in the same amounts as for maternal and child health and crippled children's services, and that the special earmarking for day care services be eliminated. And, with respect to the OASDI amendments, we suggest that every consideration be given to the possibility of further increasing the proposed benefit level.

Thank you for the privilege of appearing before you once again to express our views.

Senator LONG. What do you think it would cost to eliminate the deductibles? What is your estimate, if you take out these deductibles?

Mr. SCHOTTLAND. This would depend on what was done with the rest of the bill, Senator.

In the House hearings there was considerable discussion about reducing the number of hospital days in order to take care of the extra

costs, and although our association is not enthusiastic about the reduction of the number of hospital days, if we had to make a choice, we would prefer the reduction of hospital days to balance the cost toward the deductibles. I understand that one estimate was that if the hospital days were reduced to 45 that this would balance the cost by eliminating the deductibles.

I have not had the opportunity to go into the figures, but we would be very glad to go into them and file an additional statement to the committee.

I note that Department has already made available these figures.

Senator LONG. The thought that occurs to me is that the average person is in a position to pay a small amount. If he has some income he can pay for a small amount of medical expense. Where he needs the help it seems to me is where he runs into a great amount of medical expense and that seems to this Senator to be the weak spot in the bill, that if a person has a very high medical expense he would become destitute with nobody to provide for him.

If you reduce the number of days and reduce the deductibles that would not be good.

Mr. SCHOTTLAND. What is happening now, Senator, is that a large percentage of new cases coming on old-age assistance are coming on solely because of medical expenses and they are not necessarily large expenses.

In other words, the persons getting a small income of $70, $80, or a hundred dollars a month from OASDI or from a combination of OASDI and some private income, and then he has a small medical bill and he simply can't make it, he comes on old-age assistance in order to take care of his medical care expenses.

Now, as you keep the deductible in and as you raise the deductible you just are going to bring in more people into the public welfare department and old-age assistance, and this is our reason for being opposed to the deductibles.

Senator LONG. Well, as far as my State is concerned, it tries to encourage anybody who has any right to draw a welfare check to come in and to apply for it and to make himself eligible. If he is entitled to it he ought to be in there asking for it. And Louisiana does not try, and I don't think California where you were the commissioner does either, to put the welfare office on a back street as though there were something shameful about going in and asking for public assistance, if your economic circumstances are such that you need it.

We had some of our people going in to qualify for public assistance, as you mentioned, because they wanted to be eligible for hospital care. If you had a good Kerr-Mills program, of course, that might not be necessary but if you have got an inadequate Kerr-Mills program as is the case in most States then I guess it perhaps would make sense to do that.

Mr. SCHOTTLAND. I don't want to be misunderstood, Senator, as saying we don't want people who are needy to come into the public welfare department but our preference is that the social insurance part of this bill should carry the burden, and that if it is possible to take care of this problem through social insurance it is better than having them come into the welfare department.

I agree with you if you had a good Kerr-Mills program this would solve some of the problems. But remember that the Kerr-Mills pro-

am with all due respect, is still a relief program. It is still an income test and needs test program, and in most States the division between Kerr-Mills and old-age assistance is in some States a bookkeeping division rather than a realistic division.

Senator LONG. I have never seen a program treated more like an unwanted stepchild than the Kerr-Mills program by the Department. Someone was up from my State awhile back and called over and asked to inquire about the Kerr-Mills program and the immediate response of the Department was "Oh, don't you know it doesn't work? It is no good." That has been the reception of the Department to the Kerr-Mills program all along but in spite of that it has really done some good.

Mr. SCHOTTLAND. It has. We are in favor of it.

Senator ANDERSON. I will say to my colleague that the facts show the Department hasn't discouraged it. You work right along in this field, people who carry out the welfare and medical assistance program, you ought to be an expert witness in this field; has the Department of HEW really dragged its feet on this implementation of MAA?

Mr. SCHOTTLAND. I know the statement was made before this committee and I can tell you from personal experience both from my own personal experience and with intimate contact with the Department this is completely untrue. They have done everything to beat the bushes, to push this MAA program. Their people have been out in the field helping to formulate the State legislation, and I know of few programs where there has been greater push on the part of the Department than there has been in MAA and particularly since in the early stages of the older King-Anderson bill when this charge was first made. The Department, I think, has been very sensitive to this, and has done much more than they have done on previous amendments, so that the thing is just completely untrue.

Senator ANDERSON. I thank you very much for that because that has been my experience in it. It has been the testimony of many people who have written in saying they didn't feel this was a proper charge against the Department. They had done a good job of pushing it.

As a matter of fact, the MAA program has probably moved faster than many of the other programs that are available to HEW; is that not correct?

Mr. SCHOTTLAND. That is correct.

Senator ANDERSON. You mentioned the fact you were worried about these deductibles, and if you think you are worried about them I think maybe you should recognize that I have probably been through the bill a little bit myself.

The previous King-Anderson bill proposed three sets of deductibles, one for 45 days and no deductible, one for 90 days and a small payment equal to 1 day, and 180 days and a slightly larger payment.

Some in the medical profession advised me that was the wrong procedure, that a patient could not tell how long he was going to be in a hospital, and we shouldn't put up against him that sort of a choice. You ought to give him a reasonable amount of days in the hospital, such as 60 days, and make him pay a small deductible, and he would be better off.

What is your opinion of that? I am not trying to say that you aren't perfectly sincere in your suggestion that no deductible should be charged. But is there not some basis for the theory that since you can't tell in advance how long people are going to be there, there had

better be some way of protecting them against what Senator Long has so well said is catastrophic illness.

Mr. SCHOTTLAND. This is very true, we cannot tell how long a person is going to be there, but I don't think the deductible, particularly a small deductible, really makes much difference in this regard.

Senator ANDERSON. I am not trying to quarrel with you at all because I spent an awful lot of time on this thing and came out with all sorts of answers and I am anxious to have your answer as a person who has testified many, many times before this committee and knows a great deal in this field.

You would prefer any program that had 45 days and no deductible to the present program included in the bill?

Mr. SCHOTTLAND. Correct.

Senator ANDERSON. Now, the average length of stay for people under 65 is 7.6 days now, I believe, and for people over 65, 14.1 days.

So they do tend to stay a little longer than the average person and, therefore, many more of them staying a considerable time.

I appreciate your statement. I am not going to ask you questions. I was worried about one thing as you went through it if I can find it. You said the bill will leave out many classes entirely, something like that.

Do you recall your phrase?

Mr. SCHOTTLAND. Yes, sir.

Senator ANDERSON. What was that? Explain that to us a little what was being left out.

Mr. SCHOTTLAND. Yes.

This is in the public assistance part of the bill. The requirement as now written is that a medically needy person must qualify as far as the nonincome part of the bill is concerned, must qualify for one of the categories, for the other provisions of the categories, so that let us say a person is 60 years of age, and he is not old enough for old-age assistance, he is not blind, and he can't qualify under aid to dependent children or AFDC.

There is only one thing wrong, he doesn't have any money and he is broke.

Now, he can't qualify under this bill for medical care because he won't be able to come under the categories. So that we believe that if there could be an extension of this for the same kind of medically needy people who may not meet the specific requirements in the Federal categories, that this would be a tremendous improvement in the bill.

Senator ANDERSON. I was only trying to ask indirectly about it. If you felt the deficiency was in the King-Anderson section of the bill or the Kerr-Mills sections of the bill or the supplementary benefits. Apparently it is not in those at all that you are talking about.

Mr. SCHOTTLAND. It is in the Kerr-Mills part, the public assistance part of the bill.

Senator ANDERSON. Thank you; that is all.

Senator LONG. Senator Williams?

Senator WILLIAMS. Mr. Schottland, I understood you to say you were completely satisfied with the push which the Department had given to the Kerr-Mills bill in getting it implemented in the various States.

Mr. SCHOTTLAND. That is correct.

Senator WILLIAMS. Would you be satisfied if, after the enactment of this bill, they gave it the same kind of push and the same attention they are giving the Kerr-Mills bill.

Mr. SCHOTTLAND. Yes, I would.

Senator WILLIAMS. I am glad to hear that because in our area, in fact, I have talked with the Department on occasions, and received the same response that the Senator from Louisiana referred to when they told me that the Kerr-Mills bill wasn't worth considering, and when I was trying to get them over in our State to help the legislature getting a little push on getting it implemented, they say you won't have anything when you get it done and that is exactly what they told me.

So, I am glad that you are satisfied with it because it is nice to find somebody satisfied with it. [Laughter.]

Now, one other question: in connection with this $1,200 limitation has it been your experience that the limitation on the amount that some of these people can earn has had a tendency to cause them to drift over into the welfare department more so than they would if they had been with a higher limitation or been allowed to keep more of their earnings, what effect have you seen on that?

Mr. SCHOTTLAND. Senator, if I might be permitted to back into that question, and if I might with the agreement of the committee just dissociate myself as a representative of the American Public Welfare Association and give my personal views on it: I think the Congress is always faced with the problem of the philosophy of social security and my own personal reaction is that it is important to maintain a philosophy that this is insurance against wage loss, against income loss. This is not a straight pension program for everyone reaching a certain age.

I think this is important for many reasons. In the first place, a straight pension program would be terribly costly, and in terms of priorities, for the amount of money involved there are certainly many, many priorities that ought to be considered before we go into this expensive thing.

So, we are always faced with the problem of how far the exception should go.

I do not believe that there are very many people, if one looks at the statistics, who are earning less than $1,200, who could easily be earning $1,500 or $1,800. Most people are either fully employed or partially employed at something and certainly in excess of the $2,000 mark, so that a slight increase, I don't think is going to be terribly helpful in terms of numbers.

Nor, do I feel that the $1,200 is actually resulting in bringing many people onto the relief rolls. I don't think that if you examine the figures on the income of persons on relief you will find very many persons in that narrow range, so that I do not believe this is causing an increase in the relief rolls.

Senator WILLIAMS. I wasn't suggesting that it be removed entirely. That wasn't the question. But if it was raised to $1,500, $1,800, or $2,000, I just wondered what effect you thought that would have in——

Mr. SCHOTTLAND. I don't think it would have much effect whatsoever in keeping people off the relief rolls. I think psychologically it would have a very important effect on older people who would feel that they, the few who have the opportunity to work, I think it would have a good affirmative psychological effect, and I believe, although

we haven't taken a position on that recently, I think the association is in favor of some liberalization of this exemption.

Senator WILLIAMS. There would be a certain amount of dignity to the fact that the man earned it rather than having to accept it on welfare if he was able to earn it.

Mr. SCHOTTLAN. Correct; and I am personally in favor of a liberalization.

Senator WILLIAMS. Thank you.

That is all.

Senator LONG. Senator Douglas?

Senator DOUGLAS. Mr. Schottland, you were Commissioner of Social Security from 1954 to 1958?

Mr. SCHOTTLAND. Yes, sir.

Senator DOUGLAS. You were appointed there by President Eisenhower?

Mr. SCHOTTLAND. Yes, sir.

Senator DOUGLAS. I take it your appointment was approved by the two Senators from California at that time, Senator Knowland and Senator Kuchel?

Mr. SCHOTTLAND. That is correct. At that time, yes. However, I would like point out, I was then and I have always been a Democrat.

Senator DOUGLAS. I want to point out you were appointed by a Republican.

Mr. SCHOTTLAND. That is correct.

Senator DOUGLAS. And yet you are in favor of this bill?

Mr. SCHOTTLAND. That is correct.

Senator DOUGLAS. You served under two Secretaries?

Mr. SCHOTTLAND. Served under three, Senator, Mrs. Hobby, Mr. Folsom, and Mr. Flemming.

Senator DOUGLAS. And Mr. Folsom and Mr. Flemming have also declared themselves in favor of the King-Anderson bill.

Mr. SCHOTTLAND. That is correct.

Senator DOUGLAS. So that the three of you who served a major portion of the time during the Eisenhower administration support the bill.

Mr. SCHOTTLAND. That is correct, because it is a good bill.

Seator DOUGLAS. I think you have supported the idea all along but I don't think Mr. Folsom and Mr. Flemming did until they were detached from the administration and attained a degree of philosophic impartiality which they were not then permitted to exercise.

You shouldn't comment on that. I throw it in for what it is worth.

I was very much pleased by your statement that you believe the services of specialists, such as anesthetists, radiologists, pathologists, inside the hospital should be included under the basic plan.

I would like to ask you if you approve of our amendment No. 156? What this amendment would do would be to permit coverage under the hospitalization plan of the costs of the services of these specialists where the existing or future voluntary agreement between the hospital and the specialist is that the hospital includes these costs but would make this contingent upon voluntary agreement between its bill and, in some fashion, pays the specialists. The present bill would permit payment for these services only under the voluntary plan and when an individual bill is rendered by the specialist.

The American Medical Association is trying to make it appear that this amendment would blanket all of them into hospital services. I

tried to make it clear yesterday that that was not the intent, and I have consulted with experts and they tell me that that is not the effect of this amendment. It really would restore freedom of choice to doctors, at least as to whether or not they wish to contract with hospitals to have their services included in the hospital bill.

Mr. SCHOTTLAND. As I read this amendment, I don't have the bill before me so it is difficult to follow but as I read the amendment, I think I understand it, Senator.

Our association would be in favor of this amendment.

However, we believe it ought to go much further.

Senator DOUGLAS. You would automatically blanket all of them in?

Mr. SCHOTTLAND. Correct.

Senator DOUGLAS. The American Medical Association would automatically blanket them out.

Mr. SCHOTTLAND. Correct.

Senator DOUGLAS. And I occupy a middle ground saying if the hospital and the specialists agree upon this they would be included.

Mr. SCHOTTLAND. Correct.

Senator DOUGLAS. I believe a middle ground is very popular politically these days. It is unusual for me to find myself in that position but I can tell you it is a very comfortable feeling.

Mr. SCHOTTLAND. I would like to comment, Senator.

As an old bureaucrat, I feel that it is important that we simplify the administration of these laws. We are getting now so complicated that frequently administration overrides basic policy problems, and it is going to be extremely difficult for hospitals to separate their other costs from the costs of these groups that are excluded, and I see no reason to put onto the hospitals of the country this complicated problem, this complicated accounting problem of trying to figure out what is a pathologist's bill that is a personal thing, what part is the hospital, and it is just going to be really an accounting mess and that is one reason, I think it is the minor reason, but that is one reason, why I think it ought to be in there.

Senator DOUGLAS. I introduced relevant evidence the other day in the form of a statement of a very eminent hospital administrator in New England. He pointed out that if the present provisions of the bill were to be carried out, in two actual cases which he selected, the patient in one would have 9 to 11 separate bills submitted by specialists and in the other 7 to 9 separate bills.

Mr. SCHOTTLAND. If I might be very blunt and frank, I see absolutely no logic in any of the testimony that is being—that has been given before this committee or the Ways and Means Committee or no real arguments that have been presented for excluding them except a desire of certain groups, not to have anything to do with social insurance.

Senator LONG. If I might just make a suggestion, I am going to offer an amendment one of these days to stop this three-layer business and make one layer out of the first two layers and that being the case it will solve the whole problem, there will be nothing to argue about. They will all be in the same tent.

Mr. SCHOTTLAND. I hope you succeed, Senator. We will be down here pitching for that.

Senator DOUGLAS. You will exceed Congressman Forand then because as I remember it when Congressman Forand started out 8 years ago he included physician services but not surgical services.

Mr. SCHOTTLAND. Right.

Senator DOUGLAS. Now, it is a four-layer cake.

Senator WILLIAMS. The trouble is when you cut down on the layers you get less icing, don't you?

Senator ANDERSON. I just hope, Mr. Schottland, you won't commit yourself too firmly for that until you know what is in it. [Laughter.]

In theory I favor it but in practice I am not sure.

Senator DOUGLAS. I think this discussion indicates this is a very moderate bill.

Paraphrasing Warren Hastings at his trial, I would say, "We are astonished at our own moderation."

Senator ANDERSON. Mr. Chairman, the question has frequently been raised as to whether or not the Department has pushed this along as rapidly as it has some other programs, and I would like permission to insert in the record at this point a table, showing that in the old-age assistance program at the end of 5 years, 16 States were in the program; in the aid to families with dependent children, 45 States; in aid to the blind, 46 States; aid to the permanently and totally disabled, 45 States; and the MAA program, 46 States.

So, it certainly has moved along with the general trend, and while I admit there are areas where it didn't seem to be moving along, I think in the main that the Department of Health, Education, and Welfare has done its job and I am glad to have your confirmation at that point. I would like to put it in the record.

Senator LONG. So ordered.

(The table referred to follows:)

PROGRESS IN IMPLEMENTATION OF MEDICAL ASSISTANCE FOR THE AGED (MAA)

Data on the comparative speed with which States began MAA programs shows, if anything that they received encouragement and aid in introducing this program at least equal to any that had been provided previously for other programs. The problem in implementing MAA has been that some States—despite substantial Federal encouragement and financial assistance—have not had the money to provide more than token benefits.

Progress in implementation of federally aided public assistance programs

PROGRAMS AND THEIR EFFECTIVE DATES[1]

Period elapsed after Federal aid became available	OAA,[1] Oct. 1, 1950	AFDC, July 1, 1935	AB, July 1, 1935	APTD, Oct. 1, 1950	MAA, Oct. 1, 1960
	Number of programs in effect[2]				
6 months	5	2	2	30	8
1 year	10	24	21	35	19
1½ years	10	30	28	38	26
2 years	12	35	31	40	28
2½ years	12	43	40	40	29
3 years	12	43	42	41	32
3½ years	13	45	45	43	34
4 years	13	45	45	43	39
5 years	16	45	46	45	[4] 46

[1] OAA equals old-age assistance; AFDC equals aid to families with dependent children (originally, aid to dependent children (ADC)); AB equals aid to the blind; APTD equals aid to the permanently and totally disabled; MAA equals medical assistance for the aged.

[2] Vendor payment program.

[3] Puerto Rico, the Virgin Islands, and Guam were not eligible to participate when most of these programs began. They are included as of the elapsed time after they became eligible to participate in each program under Federal law.

[4] Includes 2 States (Montana and New Mexico) expected to begin programs before the end of the 5-year period.

Senator DOUGLAS. The Department of Health, Education, and Welfare may have done its job but most of the States, being in difficult financial straits, have not been able to extend it to any appreciable number of persons; isn't that true, except in five States?

Senator ANDERSON. They haven't done a great job. I know in my own State the battle of the budget is on every year. This year they had extra assets and they put in $700,000 for Kerr-Mills and somebody wrote me and said: "We don't understand this. The people from Health, Education, and Welfare are pushing us to put in Kerr-Mills. Are they doublecrossing you with your bill?"

I wrote back and said: "No, I would be glad to see them implement Kerr-Mills, there is no quarrel about it." But I was glad to see the people of HEW were pushing that in my State at least.

It is true budgets are difficult in many States. They do cause some problems. States would like to go ahead but sometimes don't find the funds to do it.

Senator LONG. Any further questions?

Senator DOUGLAS. In my State, as I remember it, we have a little over a million persons over the age of 65, and the number on Kerr-Mills in a given month is seldom appreciably over a thousand. So this would be one-tenth of 1 percent. Now, it is true that the cumulative number, of course, those over a period of time is greater, as I understand it, something like 2 percent, but the percentage of those on old-age assistance being helped is low.

Senator LONG. Thank you so much, Mr. Schottland.

The next witness will be Mr. Irvin P. Schloss, of the American Foundation for the Blind.

STATEMENT OF IRVIN P. SCHLOSS, LEGISLATIVE ANALYST, AMERICAN FOUNDATION FOR THE BLIND

Mr. SCHLOSS. I have submitted a written statement and I would appreciate having it included in the record. I will then summarize it, if I may.

Senator ANDERSON. Without objection it will be included in full in the record.

Mr. SCHLOSS. In endorsing the provisions of H.R. 6675, I am speaking for the American Foundation for the Blind, the national voluntary research and consultant agency in the field, and the American Association of Workers for the Blind which is a national professional association of workers in all aspects of services to blind persons.

Both of these organizations had supported efforts since 1959 to provide through the social insurance system for health care services to persons 65 and over.

We were therefore very pleased to see the proposed title XVIII of this bill and hope that it will be favorably acted upon by this committee.

We were also pleased to see the inclusion of the proposed title XIX, the new medical assistance program for the medically needy. We believe this will be a very vital supplement to the title XVIII provisions.

In connection with the health care provisions under title XVIII, we believe that the needs of disability insurance beneficiaries are also acute, and would recommend to the committee that they give serious consideration to including them as well as persons over 65.

With regard to the maternal and child health and crippled children's programs as amended in H.R. 6675, we were pleased to see inclusion of that as well.

However, we would sincerely urge the committee to strengthen the program of services for crippled children substantially more than is provided for within this bill. Specifically we would like to recommend that section 202 of H.R. 6675 be stricken and that the proposed amendment we have attached to our written statement be substituted.

These amendments would do the following: They would change the name of the program from services for crippled children to services for children with physical or mental impairments as a means of more accurately describing the true intent and scope of the program.

They would substantially improve the financing mechanism, so that comprehensive health services for children with all types of impairments could be provided by the States; and they would strengthen the State plan requirements for this program, so there would be an assurance that these comprehensive services would be provided to all types of impaired children.

The term "services for crippled children" we believe has become obsolete. Originally, the program was orthopedically oriented. Over the years it has begun to serve children with other than orthopedic disabilities, but this is still on a very spotty basis. There is extensive variation from State to State.

For example, with regard to eye conditions, only 25 States serve children with congenital cataracts; 16 States serve children for refractive errors; 27 States serve children for strabismus, a condition commonly called crossed eyes which will result in substantial loss of vision in the affected eye if it is not treated earlier; and 31 States serve children for other types of eye diseases. These figures I am quoting from are 1962 statistics prepared by the Children's Bureau, and they are the most recent available to us.

If we were to analyze State-by-State figures for these same four categories, we could find even more extensive variation in detail.

For example, in some States there will be one or two children treated for some of these conditions. In other States there will be several hundred. So we know that the children in States that only treat a few or none at all do not neglect, so to speak, the children because they do not exist but for other factors; namely, the limiting definition of the term "crippled," which even to professional people still means orthopedic disability, as well as lack of adequate financing for the program.

I have taken the liberty in my original statement of extracting tables from the Children's Bureau statistics of States from which the members of the committee come to illustrate this point. In most of the States services are very low to these children, with the exception of Kentucky and New Mexico.

The financing amendment we are proposing would finance this program in a way comparable to the public assistance titles under the Social Security Act, and it is actually virtually identical to the proposed title XIX financing method for the medical assistance program.

It would provide for a variable formula based on per capita income which would assure the highest per capita income States of 50-percent financing and the lowest States of 83-percent financing.

I would like to emphasize, too, that not only are vision problems a serious area of neglect here, but the same is true of cerebral palsy, impaired hearing, and other disabling conditions. This program is principally a preventive program, one designed to prevent disability as well as one designed to mitigate the disabling effects of some of these conditions.

With regard to eye disabilities, there are certain eye conditions which, if not treated in early childhood, will result in substantial loss of vision virtually to the point of blindness in the affected eyes.

Ophthalmologists say that the optimum age for catching some of these conditions and treating them to prevent the disability of blindness is between 8 months and 4 years.

Congenital glaucoma, for example, could be arrested in early childhood and spare children from going through life as blind persons, having to be educated as blind persons, training under the vocational rehabilitation program, and being assisted to find employment as well.

In effect most of these are federally assisted programs; and even though the mechanism of financing we are suggesting here would appear to be initially expensive, in the long run, aside from the humanitarian values, it would actually be more economical by saving money in these other federally assisted programs.

As far as the changes we would recommend in the State plan provisions are concerned, one of these would be to require that the program be in effect in all political subdivisions of a State. This is not now the case. Another would be that the State agency serving blind persons be authorized to administer that part of the State plan affecting vision disability and that the State mental health agency be authorized to administer that part of the State plan affecting mental or emotional problems. And then perhaps one of the most important would require that the State plan include a priority system to give top priority to treatment of conditions which can prevent serious disability if treated and to disabling conditions which can be mitigated if treated early.

We believe this program is just too important to be underfinanced as it has been historically.

We would hope that the committee would accept the amendments we are proposing. They have the support, incidentally, of the six major national organizations of and for the blind in this country. In addition to the American Foundation for the Blind and American Association of Workers for the Blind, they are supported by the American Association of Instructors of the Blind, the American Council of the Blind, the Blinded Veterans' Association, and the National Federation of the Blind.

With regard to the title III provisions of the bill, we would like to recommend to the committee that they include the provisions of S. 1787 as an amendment to title III of H.R. 6675.

As you know, these provisions were passed by the Senate during the last Congress in the social security bill that died in conference. The effect would be to permit blind persons with at least six quarters of coverage to continue receiving disability insurance cash benefits without regard to ability to engage in substantial gainful activity.

This last phrase is part of the current definition of "disability." It is administered in a way that varies considerably from State to State so that ability to engage in substantial gainful activity could

conceivably mean earnings as low as $600 or anywhere from $600 a year up to a maximum of $1,200 a year. Thus a disability insurance beneficiary who does become rehabilitated could conceivably actually lose cash in terms of having much lower earnings than his disability insurance benefits would be.

We believe that this would make the disability insurance program as far as blind persons are concerned similar to the way that the disability compensation program for veterans works and, in fact, serve as an incentive to rehabilitation rather than as a deterrent to rehabilitation.

Three organizations have authorized me to indicate their support for the inclusion of S. 1787—the American Foundation for the Blind, the American Association of Workers for the Blind, and the Blinded Veterans' Association.

In conclusion, we believe that enactment of H.R. 6675, with the amendments which we have proposed, would substantially improve the health and well-being of our senior citizens, of medically needy individuals of all ages, of disabled children, and of disabled adults.

Thank you.

(The prepared statement of Mr. Schloss follows:)

STATEMENT OF IRVIN P. SCHLOSS, LEGISLATIVE ANALYST, AMERICAN FOUNDATION FOR THE BLIND

Mr. Chairman and members of the committee, I sincerely appreciate this opportunity to appear before you in support of H.R. 6675, the Social Security Amendments of 1965.

In endorsing this bill, I am presenting the views of the American Foundation for the Blind, the national voluntary research and consultant organization in the field of services to blind persons, and the American Association of Workers for the Blind, the national association of professional workers in all aspects of services to blind persons.

Both of these national organizations have supported efforts since 1959 to enact a program of health care for the aged under our social insurance system. We are, therefore, delighted with the action of the House of Representatives in providing for the establishment of such a program under proposed title XVIII of the Social Security Act. In view of the fact that blindness in the United States is increasingly a disabling condition among older persons, with more than half of the estimated 400,000 blind persons in this country being 65 years of age and over, this proposed legislation will be particularly valuable to a substantial number of these individuals in helping them to meet the cost of sight restoration surgery and other necessary health services.

In addition, the new medical assistance program provided under proposed title XIX of the Social Security Act will be especially helpful to those needy blind persons who do not qualify for health care benefits under title XVIII. Both of the organizations I am representing heartily endorse this program as well.

We deeply regret that H.R. 6675 as passed by the House of Representatives did not include disability insurance beneficiaries for health care benefits under proposed title XVIII of the Social Security Act. We believe that the need of this group for adequate health care services is as acute as it is for aged beneficiaries and hope that the committee will remedy this situation.

We heartily endorse the improvements made by this bill in the maternal and child health and crippled children's programs under title V of the Social Security Act. However, we do not believe that the program of services for crippled children is strengthened enough by this bill to meet the actual need. Therefore, we strongly urge the committee to strike out the provisions of section 202 of H.R. 6675 and substitute the attached amendments.

These amendments are designed to make urgently needed improvements in what is now called services for crippled children under part 2 of title V of the Social Security Act. These amendments would:

1. Change the name of the program to "services for children with physical or mental impairments" to more accurately reflect the broad range of conditions to be treated.

2. Improve the Federal-State financing arrangements to make it possible for increased numbers of children with a variety of seriously disabling conditions to be served.

3. Strengthen State plan requirements to assure more adequate services.

As you know, the original emphasis in this program was treatment of children with orthopedic disabilities. Hence, the name "services for crippled children" was an appropriate one. Over the years, however, other types of handicapping conditions were included within the scope of the program. These conditions include epilepsy, congenital malformations, impaired vision, impaired hearing, cerebral palsy, and mental retardation.

Unfortunately, there is wide variation between the States in the conditions treated according to the definition of "crippled" used by them. To both professional and lay persons, the term "crippled" still refers to an orthopedic disability. We firmly believe that changing the name of the program in accordance with our recommendation will give the program substantially better visibility to the parents of children who should be served by it and result in increased State financial support as well.

We should like to cite some statistics compiled by the Children's Bureau for the year 1962—the most recent available to us—to illustrate the extreme variation in services for eye conditions. The same variation exists for many other conditions, including impaired hearing and cerebral palsy. Only 775 children in 25 States were treated for congenital cataracts. Only 6,224 children in 16 States were treated for refractive errors. Only 12,400 children in 27 States were treated for strabismus (crossed eyes), a condition which is usually readily correctible but which inevitably results in serious loss of vision if not corrected in time. A total of 4,006 children, in 31 States were treated for other diseases of the eye that year.

The total number of children treated for eye conditions in 1962 was 23,405, or 6.1 percent of the total number of children treated that year for all types of conditions. For cerebral palsy, the figure is 8.1 percent; and for diseases of the ear and mastoid processes, the figure is 6.7 percent.

These figures do not mean that the remaining States did not have children with these specific conditions who were eligible for service. Rather, they mean that the States which did not treat for these conditions do not cover them at all in their programs. A further analysis of these figures on a State-by-State basis will indicate that in many States only one or two children were treated for these conditions. Again the reason is not lack of additional children eligible for treatment for these conditions but lack of adequate casefinding coupled with lack of adequate financing.

I have taken the liberty of preparing a table listing the States of members of the committee and the number of children treated in them for these same conditions in 1962. I believe that this table will illustrate in dramatic fashion the need for changing the name, improving the financing, and making State plan requirements stricter.

Number of children receiving physicians' services

	Congenital cataracts	Refractive errors	Strabismus	Other diseases of the eye
Arkansas	0	0	0	0
Connecticut	0	0	2	1
Delaware	0	0	0	0
Florida	0	1	2	4
Georgia	2	2	1	4
Illinois	0	0	4	11
Indiana	0	0	2	0
Kansas	4	0	1	0
Kentucky	18	61	200	140
Louisiana	0	0	0	51
Minnesota	0	0	3	1
Nebraska	0	0	1	2
New Mexico	10	898	257	181
Tennessee	2	0	2	10
Utah	2	5	16	10
Virginia	0	0	0	0

There can be no question that this program needs substantial extension and improvement. The amendments we are suggesting would provide the means for accomplishing this needed strengthening within a relatively short period of time.

With more adequate Federal financial support, with authorization for a specialized State agency to serve the group it knows best, and with a proper system of priorities based on the handicapping effects of a condition, no child need be deprived of services which would assist him to lead a more normal life as a result of prevention or correction of a handicapping condition.

Subsection (a) of the amendments would alter the name of the program from "Services for crippled children" to "Services for children with physical or mental impairments." As we indicated earlier, the purpose of this change is to clarify the purpose and scope of the program in serving children with nonorthopedic disabilities as well as those with orthopedic disabilities.

Subsection (b) of the amendments supplants existing section 511 of the Social Security Act with a new section 511, authorizing Federal appropriations adequate to meet all matching funds the States are willing to devote to this program. Subsection (c) of the amendments supplants existing section 512 with a new section 512 concerning allotments to the States. The new section 512 also supplants existing section 514 of the act relating to the method of payments to States.

The proposed sections 511 and 512 covering financing of the program are similar to the Federal-State financing system used in titles I, IV, X, XIV, and XVI of the Social Security Act and virtually identical to the method and formula contained in proposed title XIX in H.R. 6675. The formula is based on per capita income of the States; and under the provisions of this amendment, the poorer States would receive as high as 83 percent Federal matching for this essential program while the highest per capita income States would receive 50 percent Federal matching. In addition, all States would receive a Federal share of 75 percent for medical administrative and supportive services, 50 percent for general administrative services, and 75 percent for training of the highly specialized personnel needed in the program.

One of the factors which has kept this vital program from expanding as it should and serving children with all types of disabilities on a comprehensive basis has been the ceiling on appropriations. As a result of this restriction of funds, children with vision impairments, for example, have not been able to get needed treatment to prevent the serious disability of blindness. As a consequence, they have had to be educated as blind persons, trained for a job as blind persons, helped to find employment as blind persons. In many instances, these individuals have become public assistance recipients. All of these programs, and many ancillary ones designed to assist our country's blind people, have in fact cost the taxpayers many times what adequate preventive services under part 2 of title V would have cost in the first place.

The improved Federal-State matching formula and financing system provided for in this amendment should have been included in this program when the Social Security Act was first enacted in 1935, just as it was for the public assistance programs. We sincerely hope that the committee will correct this longstanding oversight.

Subsection (d) of the amendments amends section 513(a) to strengthen the State plan provisions. Among the changes made in the State plan requirements is that the program must be in effect in all political subdivisions of a State. Originally, the emphasis in this program was in rural areas. However, the changing population pattern requires that we serve more adequately children in urban areas, particularly those from low-income families, where the prevalence of disabilities seems to be greater.

Another important change requires State plans to establish a system of priorities for treatment, so that conditions which may worsen into severely handicapping disabilities will be assured of early adequate treatment. The example I cited earlier about types of visual impairment which can worsen into blindness if untreated will illustrate the value of this provision. At present, impaired vision and impaired hearing are among the conditions which are not receiving adequate and early treatment as a general rule in this program.

Another change in the State plan provisions would make it possible for the State agency serving blind persons and the State mental health agency to be designated to administer those parts of the plan affecting children with vision problems and children with emotional or mental impairments respectively. The existing provision is interpreted to require that a single State agency administer the program in a given State. In some States, this is the State health agency, in some the welfare department, in others a separate crippled children's agency, in some the State university. Thus, the agency best equipped to handle some of the specific disabilities involved does not receive Federal funds for this purpose.

This has resulted either in inadequate service for the visually impaired in some States or in no service at all in others.

The use of one State agency to administer part of a Federal-State cooperative program is not a new concept. It already exists in the public assistance program under the Social Security Act with four State agencies for the blind administering aid to the blind under titles X and XVI. Similarly, 36 State agencies for the blind administer the part of the State plan affecting blind persons under the Vocational Rehabilitation Act. In both programs, this separate administration has worked efficiently and effectively. Each State should have the privilege of designating the administrative structure which best suits its own needs in a Federal-State cooperative program without being restricted by the Federal law from doing so.

Subsection (f) of the admendments we are proposing merely adds a new section 515 to the Social Security Act for the purpose of defining how "the Federal impaired children's percentage" used in the financing formula is derived.

We sincerely hope that these proposed amendments to part 2 of title V of the Social Security Act will be accepted by the committee and approved by the Congress. They have the unanimous support of the major national organizations of and for the blind—the American Association of Instructors of the Blind, American Association of Workers for the Blind, American Council of the Blind, American Foundation for the Blind, Blinded Veterans Association, and National Federation of the Blind.

The program these amendments would expanded and improve is one whose validity and significance has too long been undervalued from the standpoint of Federal financial assistance. A program designed to prevent or correct physical or mental handicaps in children deserves the best support possible from every level of government in the United States. Enactment of these amendments into law will assure the children who need this service of a chance to minimize handicapping disabilities and lead more normal lives.

We would also like to urge the committee to amend title III of H.R. 6675 concerning the disability insurance program under title II of the Social Security Act to incorporate the provisions of S. 1787. These amendments would make it possible for blind persons with at least six quarters of covered employment to become eligible for disability insurance cash benefits without regard to their ability to engage in substantial gainful activity. In effect, these amendments would make the disability insurance program similar to the disability compensation program for veterans by basing the award of cash benefits on a medical determination that blindness exists with the presumption that the condition curtails opportunities for employment and is a serious handicap in other than economic ways. The actual amount of cash benefits in the disability insurance program will, of course, vary with the number of quarters of covered employment and the amount of earnings.

The American Association of Workers for the Blind, American Foundation for the Blind, and Blinded Veterans Association have authorized me to indicate their support for inclusion of the provisions of S. 1787. Other organizations mentioned earlier as supporting the changes we are recommending in the crippled children's program will be represented at these hearings by other spokesmen in supporting inclusion of the provisions of S. 1787 in H.R. 6675.

Enactment of these provisions into law will definitely serve to spur the rehabilitation of blind persons. By providing blind persons with an economic floor from which to operate in rehabilitating themselves, the Congress will give them an opportunity to experiment with various vocations without the risk of losing their benefits should they fail in one endeavor and find it necessary to try something else. The present law on the other hand serves as a deterrent to rehabilitation; for there is no incentive to experiment when the blind person has to risk losing the security of his cash benefits when he accepts employment which may provide an income substantially smaller than his cash benefit. As you know, the term "ability to engage in substantial gainful activity" in the present definition of disability is variously interpreted across the country, so that the indivdual who earns anywhere from $600 up to $1,200 a year after rehabilitation will no longer be qualified to receive cash benefits. Since his cash benefits could easily have been double his earned income, the present definitition of disability works a hardship on the disabled individual and his family in the name of rehabilitation.

We know from the experience of World War II and Korean conflict blinded veterans—approximately 60 percent of whom are gainfully employed, taxpaying citizens—that the floor of financial security provided by their disability compensation has been an incentive rather than a deterrent to rehabilitation. We can

predict that the same will be true of blind disability insurance beneficiaries under social security.

In conclusion, we should like to respectfully urge the Committee on Finance to act favorably on H.R. 6675 with the amendments we have recommended. It is an excellent measure which will make a major contribution to the health and well-being of our senior citizens, needy persons of all ages, disabled children, and disabled adults.

PROPOSED AMENDMENT TO SECTION 202 OF H.R. 6675

Section 202 of H.R. 6675 is amended to read as follows:

Improvements in crippled children's services

SEC. 202. (a) The heading of part 2 of title V of the Social Security Act is amended by striking out "Services for Crippled Children" and inserting in lieu thereof "Services for Children With Physical or Mental Impairments".

(b) Section 511 of the Social Security Act is amended to read as follows:

"*Appropriation*

"SEC. 511. For the purpose of enabling each State to extend and improve services for locating physically or mentally impaired children and for providing medical, surgical, corrective, and other services, care, and facilities for diagnosis, hospitalization, and aftercare for children who are physically or mentally impaired, or who are suffering from conditions which may lead to physical or mental impairment, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part. 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 services for children with physical or mental impairments."

(c) Section 512 of the Social Security Act is amended to read as follows:

"*Payment to States*

"SEC. 512. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this part, for each quarter, beginning with the quarter commencing January 1, 1966—

"(1) an amount equal to the Federal impaired children's percentage (as defined in section 515) of the total amount expended during such quarter as services for children with physical or mental impairments under the State plan; 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 the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan—

"(A) 75 per centum of so much of such expenditures as are for—

"(i) services specified by the Secretary, to individuals who are applicants for or recipients of, or who have been determined to be eligible for, services for children with physical or mental impairments under the State plan, which are furnished as provided in so much of section 3(a)(4) as follows subparagraph (C) thereof, or

"(ii) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

"(B) one-half of the remainder of such expenditures.

"(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) 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 subsection, 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 services for children with physical or mental impairments 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.

"(c) 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 services for children with physical or mental impairments, with a view toward furnishing by July 1, 1970, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards, including services to enable such individuals to attain or retain self-care."

(d) Section 513(a) of the Social Security Act is amended to read as follows:

"(a) A State plan for services for children with physical or mental impairments must—

"(1) provide for financial participation by the State;

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

"(3) provide for the administration of the plan by a State agency or the supervision of the administration of the plan by a State agency, except that the State agency serving blind persons may be designated as the State agency administering or supervising the administration of that part of the State plan affecting services for children with visual impairments, and except that the State mental health agency may be designated as the State agency administering or supervising the administration of that part of the State plan affecting services for children with mental or emotional impairments;

"(4) provide such methods of administration (including, after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no uthority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are necessary for the proper and efficient operation of the plan;

"(5) 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 he may from time to time find necessary to assure the correctness and verification of such reports;

"(6) provide for carrying out the purposes specified in section 511, including provisions that priority be given to treatment of conditions which may lead to severe physical or mental disability if untreated and to existing conditions of severe physical or mental disability which may be mitigated through adequate treatment;

"(7) provide for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of the handicapped;

"(8) provide that all individuals wishing to make application for services for children with physical or mental impairments under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals who reside in the State; and

"(9) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for services for children with physical or mental impairments under the plan is denied or is not acted upon with reasonable promptness."

(e) Section 514 of the Social Security Act is repealed and section 515 of such Act is redesignated as section 514; and the section so redesignated as

section 514 is amended by striking out "services for crippled children" and inserting in lieu thereof "services for children with physical or mental impairments".

(f) Part 2 of title V of the Social Security Act, as amended by the preceding provisions of this Act, is further amended by adding at the end thereof the following new section:

"Definition

"SEC. 515. The term 'Federal impaired children's 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 (i) the Federal impaired children's percentage shall in no case be less than 50 per centum or more than 83 per centum, and (ii) the Federal impaired children's percentage for Puerto Rico, the Virgin Islands, and Guam shall be 55 per centum. The Federal impaired children's percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8); except that Secretary shall promulgate such percentage as soon as possible after the enactment of this part, 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."

Senator ANDERSON. Thank you, Mr. Schloss.

Senator Douglas?

Senator DOUGLAS. No questions.

Senator CURTIS. I want to say I appreciate the opportunity of hearing your testimony. In reference to the permanently and totally disabled within the definition of the Social Security Act, a blind person is not such per se, is he?

Mr. SCHLOSS. Not as far as cash disability insurance benefits are concerned.

Senator CURTIS. Are all of them excluded or does it depend on the circumstance and condition?

Mr. SCHLOSS. As far as cash benefits are concerned, if a blind individual has earnings which could range anywhere from $600 to $1,200 a year, as I indicated, he may be excluded from entitlement to cash benefits.

Senator CURTIS. Perhaps I didn't state my question correctly. Would the disability of blindness alone entile a person to a rating of totally and permanently disabled so far as the Social Security Act is concerned?

Mr. SCHLOSS. At the present time?

Senator CURTIS. Yes.

Mr. SCHLOSS. No, sir.

Senator CURTIS. It would not?

Mr. SCHLOSS. No, sir.

Senator CURTIS. It would have to be accompanied by other disabilities?

Mr. SCHLOSS. No. He would have to be unable to engage in substantial gainful activity.

Senator CURTIS. Yes.

What I am getting at is this: Are there people whose main and perhaps only identifiable disability is the loss of sight, are there some of them who were in occupations and were in circumstances so that this fact alone has qualified them for the disability benefits in social security?

Mr. SCHLOSS. Yes, sir; I believe there are.

Senator CURTIS. But not a great number?

Mr. SCHLOSS. I don't believe that there are—it would be difficult for me to say how many blind people there are on the rolls. I think the last time I checked the figures with the Social Security Administration there were somewhere around 30,000 disability insurance beneficiaries who were blind.

Senator CURTIS. But those statistics wouldn't reveal whether or not they had other disabilities?

Mr. SCHLOSS. They would not; no, sir. This would be the principal disability. It is not infrequent for a blind person to have some hearing impairment, perhaps other disabilities, too. It depends on how his blindness came about. Some injuries would certainly cause other disabilities as well as blindness.

Senator CURTIS. I think the blind are to be commended and their leaders are for the accomplishments and the stress they have placed upon training and rehabilitation and self-reliance. I think it has been a very beneficial thing for our society. In addition to that I think it has helped a great many sightless persons to have a more worthwhile life.

Thank you.

Senator ANDERSON. Thank you very much, Mr. Schloss, for your appearance here this morning.

Mr. SCHLOSS. Thank you, sir.

Senator ANDERSON. We have a brief message here from Congressman James Kee, Democrat, of West Virginia. He has submitted a written statement for the record which he has asked to place in the record, preceding the oral presentation of our next witness, Dr. Judd Chapman.

Without objection, that will be done.

(The statement referred to follows:)

STATEMENT OF REPRESENTATIVE JAMES KEE, DEMOCRAT, OF WEST VIRGINIA, ON SUGGESTED AMENDMENTS TO H.R. 6675

Mr. Chairman and distinguished members of the Committee on Finance of the U.S. Senate, it is a privilege to have this opportunity to submit to your committee this statement in support of an amendment to the bill now under consideration, known as the Social Security Amendments of 1965, H.R. 6675.

As you are aware, this bill was considered and passed by the House under what is known as a closed rule, which prevented amendments being offered from the floor. It is my hope that your committee will favorably report an amendment to this important legislation which will read substantially as follows:

"Notwithstanding any other provisions of the Social Security Act, whenever payment is authorized for services which an optometrist is licensed to perform, the beneficiary shall have the freedom to obtain such services from either a physician skilled in diseases of the eye or an optometrist, whichever he may select."

Optometry is mentioned in the bill, but there are many places which should be amended in order to make clear the intent of Congress that beneficiaries of the legislation who are entitled to services which could be rendered either by a physician skilled in the diseases of the eye or by an optometrist should be free to choose any licensed member of either profession.

In a bill as voluminous as this one is, it is difficult—in fact, practically impossible—to insert the appropriate wording in the various places in order to carry out the intent of Congress and afford the beneficiaries freedom of choice; and it is for this reason that I respectfully suggest that a short section be added to the bill on page 296, to be known as section 409 and worded as set forth in the beginning of my statement. I am in absolute, full, and complete agreement with this proposed amendment.

West Virginia is a State of great beauty and, while the distances are not great, travel is difficult in many places. We have many more optometrists, particularly in the rural areas, than we have ophthalmologists.

It has been my good fortune to be a lifelong friend of Dr. William Greenspon, of my home city, Bluefield, W. Va. He is now a trustee of the American Optometric Association. Last year he received the award as "The Optometrist of the South"; in 1963, the Apollo Award, the highest honor in his profession; and he also was director of the Department of National Affairs of the American Optometric Association.

Dr. Michael A. Krupey, another Bluefielder, and a very close and valued friend to whom I am indebted, is secretary of the West Virginia Board of Optometric Examiners.

Dr. W. Judd Chapman, of Tallahassee, Fla., is also well known to me. Last year he was president of the American Optometric Association; this year he is chairman of its legislative committee and will today testify before your committee on behalf of the association, expressing their views with reference to this legislation.

There are two other amendments which I also respectfully request to be included in the bill and these pertain to the authorization of funds for grants for the health of children. The optometric profession has made substantial contributions in the field of vision care and I am confident that it was an oversight that the authority provided in H.R. 6675 omitted schools and colleges of optometry from this program. The amendments are simple, involve merely the inclusion of the word "optometry" in the appropriate place in line 14, page 150 of the bill, and the other including the word "optometric" on line 12, page 151 of the bill.

I appreciate the difficult problem which confronts your committee. However, I strongly believe that the suggested amendments are in the public interest and I hope that following thorough consideration, these amendments will be included in the bill when reported.

STATEMENT OF W. JUDD CHAPMAN, O.D., REPRESENTING THE AMERICAN OPTOMETRIC ASSOCIATION; ACCOMPANIED BY WILLIAM E. MacCRACKEN, JR., COUNSEL

Dr. CHAPMAN. Thank you very much, Senator Anderson. I am going to ask for your permission that the printed statement be entered into your record, and for the purpose of conserving time I am not going to follow that statement verbatim but rather mention certain critical areas which deserve the special attention of this committee.

Senator ANDERSON. Without objection, your statement will be inserted in full in the record.

Dr. CHAPMAN. Thank you, sir.

I am Dr. Judd Chapman, a practicing optometrist from Tallahassee, Fla., and immediate past president of the American Optometric Association.

I have with me at the table this morning Mr. William E. MacCracken, Jr., the Washington counsel of the American Optometric Association.

Senator ANDERSON. And a good friend of many of us.

Dr. CHAPMAN. Yes, sir; I realize that.

Senator DOUGLAS. A very distinguished citizen of Illinois, too.

Dr. CHAPMAN. I might point out, here, that I was tempted a little earlier this morning, when the question arose concerning the matter of method of getting married in Florida, that I was not aware that it was exactly as the one witness had indicated, and if it is true I am going back and search it out.

Senator ANDERSON. We will make no extra charge for that legal instruction.

Senator DOUGLAS. I believe California is included in there.

Dr. CHAPMAN. I would like to point out, gentlemen, that there are 17,000 practicing optometrists in the United States. Our association represents over 13,000 of that number and has an affiliation in 50 States plus the District of Columbia. We are proud also of the 450 commissioned officers—optometry officers—in the Army, Navy, and Air Force. I had the privilege yesterday afternoon of visiting our optometric installation at the Andrews Air Force Base here in Washington.

I would point out, too, that there are many subspecialties of my profession, among them being the concern we have for the visual factors of highway safety. I shall not take the time of the committee to relate others of these specialties because they are included in the printed testimony, but I would like to point out that, just as recently as yesterday afternoon, I had occasion to attend a reception at the National Academy of Sciences where the optometric members of the Armed Forces Committee on Vision submitted testimony and papers which indicated that there needs to be great improvement in the construction and in the design of automobiles for the purpose of eliminating certain hazards which are created by obstructions to the vision of the drivers of these vehicles.

Senator DOUGLAS. That was a hearing before the National Academy of Sciences?

Dr. CHAPMAN. Yes, sir.

Senator DOUGLAS. This is the foremost scientific body in the country.

Dr. CHAPMAN. We consider it to be, sir; yes.

Senator DOUGLAS. And they recognized optometrists as qualified witnesses?

Dr. CHAPMAN. I would qualify this to the degree, Senator, that this was not a matter of testimony. I think I used that terminology. This was an annual meeting of the Armed Forces Committee on Vision of the National Academy of Sciences. It was not a matter of testimony.

Senator DOUGLAS. But they admitted optometrists.

Dr. CHAPMAN. Our members are very prominent on that committee.

Senator DOUGLAS. They read scientific papers?

Dr. CHAPMAN. They read several papers there during this meeting. I only mentioned the one regarding highway safety because we are deeply concerned about that particular one.

Senator ANDERSON. Since there has been a pause or a break, you mentioned one subject here that interests me very much. It says a study of visual—no, I am sorry, the fitting of telescopic spectacles.

Dr. CHAPMAN. Yes, sir.

Senator ANDERSON. When Winston Churchill came over here in 1941, Christmastime, in a speech to the American Congress he had a manuscript a yard away from him, put on his glasses and read it perfectly, standing way back moving around as much as he could, and someone told me he had telescopic spectacles.

I, being a little over 6 feet tall, frequently go to speak at places where the podium is down at the waist level and I can't see the cussed thing to save my life and I went to somebody and tried to get telescopic spectacles. I was told you didn't have such a thing.

Dr. CHAPMAN. Senator Anderson, may I comment on that and tell you exactly what you can do?

Senator ANDERSON. Yes.

Dr. CHAPMAN. It does not require telescopic spectacles. Those are devices which are used for people who are blind and yet have, let's be sure I get this terminology right, they still have usable retinal areas in the eye where a largely magnified image can create sight.

The telescopic device merely magnifies the image to such a degree that sight is permitted.

Now, what you need is the use of a trifocal lens, which is not complicated at all, which is a very common device used by optometrists for many years. This lens is designed with one part of its component at a distance of about 20 to 25 or 30 inches away depending upon where you want to put it.

I might tell you that the comptroller of the State of Florida approached me one time with a problem of attending conventions, and I suspect this is part of your problem as well. He was not able to read the name tags on various delegates and he felt that this was not in the best political sense, so we adjusted a pair of trifocals for that distance and he could stand away as far as about 6 feet and read very easily the names of the attending delegates.

Senator ANDERSON. I have worn bifocals and trifocals but I didn't know you could get a special adjustment and read a yard away.

Dr. CHAPMAN. Yes, sir.

Senator ANDERSON. Thank you.

I charge no extra for advice and I hope you don't either. [Laughter.]

Dr. CHAPMAN. No, sir; I am pleased if there are any other questions of that nature you would like to ask me. Just feel free to do so.

I would also like to point out, too, that the 10 optometry schools of this Nation are all nationally accredited institutions, and to also indicate the pride we have as a profession in the fact that our institutions are moving toward additional educational time. Particularly in the State of Ohio, our School of Optometry at Ohio State just recently inaugurated a full 6-year optometric degree-granting program.

Senator DOUGLAS. You have a School of Optometry at Columbia, do you?

Dr. CHAPMAN. Yes, sir; at Ohio State in Columbus, Ohio.

Senator DOUGLAS. Columbia, in New York?

Dr. CHAPMAN. I am sorry, there was one at Columbia University years ago but there is not one there at this time.

I misunderstood you; I thought you were saying Columbus, Ohio, at Ohio State. No, there is not one at Columbia now.

Senator DOUGLAS. But there used to be?

Dr. CHAPMAN. Yes, sir.

We also are inaugurating a similar 6-year program at the School of Optometry at the University of Indiana. Plans are underway for the optometry school at the University of California to go to a full 6-year program.

Over 75 percent of all Americans go to optometrists for vision care. I want to point out that there is a difference between optometric vision care and medical vision care.

Senator ANDERSON. May I ask you a question?

Dr. CHAPMAN. Yes, sir.

Senator ANDERSON. I wondered about this.

Over 75 percent of all Americans go to the optometrists when they need vision care. Not 75 percent of all Americans, but those needing vision care go to an optometrist.

Dr. CHAPMAN. That is correct.

Because of this difference in the two types of services rendered by the specific professions mentioned, we feel very strongly that the individuals of this Nation who are in need of such care, should have the freedom to choose which profession they propose to utilize.

Congress has shown its clear intent that more optometrists should be trained to care for the vision needs of the people of the United States.

Last year, Senate bill 2180, the Williams-Roberts bill, provided loans for optometric students and also loans for the construction of additional optometric facilities.

I would point out here that if H.R. 6675 is passed without the proposed freedom-of-choice amendment which is proposed in my testimony, there is every chance that these increased numbers of optometrists will not be available to the recipients or to those who need this type of vision care.

The House Ways and Means Committee in this bill sought to eliminate this problem by appropriate language in the present bill.

However, there are certain sections of it where the language does not adequately portray this freedom-of-choice method.

Title II of the bill, for example, calls for a comprehensive health care program for needy children, and optometry services in this particular program are completely overlooked.

Senator DOUGLAS. What page is covered in that statement?

Dr. CHAPMAN. Senator, I belive it is on page 150 and 151. I believe, as I proceed with this, Senator Douglas, the specific area can be pointed out. I think I have it. May I continue and come back to it?

Senator DOUGLAS. Certainly.

Dr. CHAPMAN. Thank you.

Project Head Start, having to do with the poverty program, has indicated that there are over 700,000 preschool children who need certain types of vision care and screening. Our association was the very first to offer our complete cooperation in the care of these 700,000 children to the very best of our ability to do so.

Senator Douglas, referring back to your question, the pages are 147, 151, and 150.

I would like to quote from a statement which has been prepared for this committee by Senator Harrison Williams of New Jersey:

> I call your attention to page 60 of the House committee's Report No. 231. The first item on that page about conditions which interfere with the growth, development, and education of children entering school says about 10,200,000 schoolchildren are in need of eye care. Optometrists take care of the vast majority of vision needs of children and yet that section to be found on page 150 of the bill, which authorizes funds to take care of these needs, provides that schools of medicine with appropriate participation by schools of dentistry should take care of them.
>
> Nothing is said about the schools and colleges of optometry who are best equipped to take care of the child's vision requirements.

We, therefore, recommend, gentlemen, the following two amendments to correct this inequity. That on page 150, line 14, after the word "dentistry" insert the words "or optometry."

And on page 151, line 12, strike out the word "both" and insert after the word "medical" the word "Optometric."

These two amendments would merely make our schools and colleges eligible to apply for grants under this program.

There are a number of other places in the Social Security Act where amendments would be necessary in order to make clear the intent of Congress that when it comes to the expenditures of Federal funds for vision care, beneficiaries should be free to avail themselves of the services of optometrists if they so desire.

But instead of attempting to correct each and every one of these we would respectfully suggest that the following be inserted as section 409 on page 296 of the bill:

Notwithstanding any other provisions of the Social Security Act, whenever payment is authorized for services which an optometrist who is a graduate of an accredited school of optometry, is licensed to perform, the beneficiary shall have the freedom to obtain the services of either a physician skilled in diseases of the eye or an optometrist, whichever he may select.

This amendment adds nothing to the program nor does it take from it. It simply recognizes the fundamental American concept of an individual's freedom. There is no additional coverage. It provides no additional services, nor does it enlarge the cost of the program.

We believe the expressed will of the Congress over the years with respect to providing this very necessary option to beneficiaries of Government sponsored health programs should be continued by making this correction in the Social Security Act.

I am prepared, gentlemen, to answer any questions that you might have regarding my testimony or the position of my profession in this matter about which we feel so deeply and which we are so deeply concerned. I thank you for the opportunity of having these moments with you.

(The prepared statement of Dr. Chapman follows:)

STATEMENT OF W. JUDD CHAPMAN, O.D.

Mr. Chairman and members of the committee, it is both a privilege and a pleasure to again appear before this committee, to present the views of the American Optometric Association concerning the Social Security Amendments of 1965, H.R. 6675.

As the immediate past president of the association, I am a member of its board of trustees. I am engaged in the practice of optometry at 205 South Monroe Street, Tallahassee, Fla. I graduated from Northern Illinois College of Optometry in 1949, having previously atended the University of Florida. Subsequently I took postgraduate work in the contact lens field at the School of Optometry, University of Houston. I am a member of the American Academy of Optometry, American Optometric Foundation, a former president of the Florida State Board of Examiners in Optometry and hold a Reserve commission in the U.S. Air Force, Biomedical Sciences Corps (optometry).

The American Optometric Association is an affiliation of State associations in the 50 States and the District of Columbia. Our membership includes optometrists who are commissioned and on active duty in the Army, Navy, and Air Force (of which there are some 450). Also, some of our members are employed by the Federal Government in its various agencies. There are approximately 17,000 practicing optometrists in the United States, and most of that number are members of our association.

The stated purposes of the association are to advance, improve, and enhance the vision care of the public; to unite optometrists; to encourage and assist in the improvement of the art and science of optometry; to elevate unceasingly the standards and ethics of the profession of optometry; and to protect and defend the inalienable right of every person to freedom of choice of practitioner.

Optometry is a specialized field, but contains within its scope certain subspecialties. Among these subspecialties are visual training, the fitting of telescopic spectacles and similar devices to the near blind, contact lenses, visual problems in aeronautics and space, the study of visual factors in highway safety, industrial optometry, and the relations of proper lighting and similar factors to safety, efficiency, and productivity in the factory, office, schoolroom, and the home.

An optometrist must be a graduate of an accredited school or college of optometry and must have passed the licensing examination of the board of optometry in the State where he practices. In addition, he must conform to rules of practice prescribed by State law and his licensing authority. He becomes a member of the American Optometric Association only through membership in his State optometric association. In order to retain his membership he must conduct his practice in accordance with optometry's code of ethics.

Optometrists take care of the vision requirements of some 90 million Americans. Over 75 percent of all Americans go to an optometrist when they need vision care. The remaining 25 percent go to physicians skilled in diseases of the eye or ophthalmologists. Physicians are by statute privileged to practice optometry but that does not mean that optometric vision care and medical vision care are identical. They are in fact different. Time will not permit me to explain the differences but because of them, the individual should be free to choose a practitioner licensed either as a physician or as an optometrist. It is our responsibility to prescribe orthoptics, visual training or corrective lenses when we determine that they are necessary and to supervise and instruct our patients in their use. In order to make a complete examination and to determine the proper prescription to improve a patient's vision, it is required that we have the confidence of our patients and that we secure their cooperation. In order to establish such a relationship, it is essential that the patient realize that he is the one who has selected his practitioner and is free to make a change any time he believes that it would be in his interest.

Vision is one of God's greatest gifts to man. H.R. 6675 and the committee report together consist of 560 printed pages containing tables which are in very fine print. One needs comfortable vision in order to read and inwardly digest this material. While this bill provides benefits for the young and old, its primary purpose is to assist those over 65 years of age. At that point in life, over 90 percent of our fellow citizens are in need of vision care which can be provided by members of our profession.

Without the services which optometrists perform, most Americans would not be able to function at their maximum productivity in our complex technological society.

In passing H.R. 8546 last year to provide loans for optometric students, Congress expressed its clear intent that more optometrists be made available to take care of the vision problems of our children, our elderly, and in fact all age groups. If H.R. 6675 is passed without the amendment to be known as section 409 of the bill their right to use this manpower will be substantially curtailed.

The House Ways and Means Committee sought to resolve this problem by inserting in the appropriate places language which they believed would allow beneficiaries of the act the freedom to determine their choice as to the qualified discipline to serve their vision needs.

For instance, there is a provision in the public assistance amendments under "Definition of Services" (sec. 1905, p. 142) authorizing payment for "eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, which ever the individual may select."

Section 1902(12)(a) on page 128 provides "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."

In excluding from the basic and supplementary plans (title I, sec. 1862, p. 88) "eyeglasses, or examination for the purpose of prescribing, fitting, or changing eyeglasses, etc.," it was clearly the intention of the House committee to exclude all vision services which either a physician or an optometrist might render.

However, there are a number of areas in this bill where it is not clear that the beneficiary may chose between optometrists and physicians skilled in diseases of the eye for services which an optometrist is licensed to perform.

Under the basic and supplementary plans, for example, patients of physicians can be reimbursed for examinations ending in referral for surgical or pathologi-

cal treatment of the eye, for contact lenses, for prescribing and fitting artificial eyes, and for orthoptics or visual training. Patients of optometrists, however, would not be reimbursed for these services.

The services of physicians, dentists, nursing homes, and others are clearly covered under the definition section on public assistance but the optometrists' services are not. Eyeglasses are to be available at the States option if prescribed by either a physician skilled in diseases of the eye or by an optometrist, but, if they are not provided, and remedial care is not interpreted to provide optometric care, physicians' services may be provided which include vision service. Under these conditions the vision services to patients of the physician are reimbursed but not similar services to patients of optometrists. This can result, and, in fact has resulted, in payments being made for physician services, including examination of the eye, orthoptics, and visual training, while payments are denied to optometrists who have rendered those same services.

Under the bill, an optometrist or a physician can be reimbursed for determining whether an individual is blind but payment for services following such determination is left in doubt. There have been many instances where physicians have been paid for the necessary aftercare, but optometrists, although they rendered the same care, were denied payment.

The services of optometrists are completely overlooked under title II of this bill although comprehensive health care of the needy child is mandated. This despite the fact that our association is now busily engaged in Project Head Start, which plans to use optometrists in serving the vision needs of approximately 700,000 preschool children of the poor this summer. The House committee report indicates that a high priority should be given to caring for the vision needs of the young beneficiaries of this title.

Section 532(b) on page 150 of the bill authorizes grants for these services to "any school of medicine (with appropriate participation by a school of dentistry)." This same section on page 151 provides that no project shall be eligible "unless it includes * * * at least such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in the regulations of the Secretary." The way this section is drafted precludes the utilization of any of the authorized funds for projects in schools or colleges of optometry.

We therefore recommend the following two amendments to correct it:

On page 150, line 14, after the word "dentistry," insert the words "or optometry."

Page 151, line 12, strike out the word "both" and insert after the word "medical," the word "optometric."

These two amendments would merely make our schools and colleges aligible to apply for grants under this program.

There are a number of other places in the bill where amendments would be necessary in order to make clear the intent of Congress that when it comes to the expenditures of Federal funds for vision care, beneficiaries should be free to avail themselves of the services of optometrists if they so desire, but instead of attempting to correct each and every one of these, we would respectfully suggest that the following be inserted as section 409 on page 296 of the bill:

"Notwithstanding any other provisions of the Social Security Act, whenever payment is authorized for services which an optometrist, who is a graduate of an accredited school of optometry, is licensed to perform, the beneficiary shall have the freedom to obtain the services of either a physician skilled in diseases of the eye or an optometrist, whichever he may select."

This amendment adds nothing to the program nor does it take from it. It simply recognizes the fundamental American concept of an individual's freedom.

We believe the expressed will of the Congress, over the years with respect to providing this very necessary option to beneficiaries of Government-sponsored health programs, should be continued by making this correction in the Social Security Act.

Mr. Chairman, I wish to thank you and the members of this committee for the opoprtunity to once again speak up for the visual welfare of our Nation. If you have any questions I will be pleased to answer them.

Senator DOUGLAS. Dr. Chapman, I know the Illinois College, the Northern Illinois College of Optometry is regarded very highly. Let me ask you this: Does the American Medical Association recognize optometry as a science?

Dr. CHAPMAN. Senator, that is a difficult question to answer in just one statement "Yes" or "No." Because of differences in the methods of attack on the problems of vision over the many years that my profession has been in existence a difference in philosophy has created differences in political opinion between my group and that of medicine.

There have been times when the science of optometry has been recognized by medicine, and if you place it on an individual practitioner basis in the communities throughout this Nation, that recognition, I think is sound, by and large.

But when it comes to a political recognition of optometry as a science, there is definitely a question. There have been passed by the house of delegates of the American Medical Association resolutions declaring it unethical for medical practitioners to involve themselves with optometrists in many different ways. I wouldn't have time to give you all of these, but certain relationships with optometrists are considered unethical. In that sense you might say that organized medicine does not recognize optometry.

Senator DOUGLAS. You speak of political relationships. Wouldn't the American Medical Association say these were scientific judgments?

Dr. CHAPMAN. Well, I suspect that they would, Senator, yes.

Senator DOUGLAS. Do I correctly understand that optometry is primarily based upon the science of optics and of vision, physical science?

Dr. CHAPMAN. Yes, it is more a matter of a physical science, however. It is more a mater of physiological and psychological optics.

Senator DOUGLAS. You include psychiology as fell as optics?

Dr. CHAPMAN. And psychology as well as pathology. You see, the first requirement of an optometrist of today is to determine whether or not this eye with which he is going to deal for the next hour is a healthy eye.

If it is not, it demands the attention of a qualified medical practitioner and an optometrist is trained——

Senator DOUGLAS. And you as an optometrist will refer him to a qualified medical practitioner?

Dr. CHAPMAN. Absolutely.

Senator DOUGLAS. And not content yourself merely with prescribing glasses?

Dr. CHAPMAN. That is correct.

Senator DOUGLAS. Or corrective exercises?

Dr. CHAPMAN. Upon the determination that this is an unhealthy eye he will then proceed to utilize the various procedures which he has.

Senator DOUGLAS. The American Medical Association would deny generally that an optometrist is qualified to judge whether or not the eye is healthy.

Dr. CHAPMAN. That would be a correct statement for some leaders of the AMA, Senator and yet a great part of our training is taken up with the study of ocular pathology, with a thorough analysis and understanding of the health of the human eye.

Senator DOUGLAS. In the colleges of optometry do they have courses in the pathology of the eye?

Dr. CHAPMAN. Yes, sir; they do. But I would point out again, and emphasize, that the treatment, the surgery, the handling of the diseased eye, which by the way includes approximately 2 to 5 percent of the vision care problems of the people of this Nation, is the province of the physician.

Senator DOUGLAS. It is a common practice, is it not, for ophthalmologists, they are recognized as physicians, I believe——

Dr. CHAPMAN. Yes, sir.

Senator DOUGLAS (continuing). To refer patients to optometrists for prescription of glasses, is it not?

Dr. CHAPMAN. No, sir; that is not common practice.

Senator Douglas. That is not common practice?

Dr. CHAPMAN. No. Because you have to add still another service, which is that of the optician. You see you have the three "O's," and that "O."

Senator DOUGLAS. You mean that the ophthalmologist will recognize the optician but not the optometrist?

Dr. CHAPMAN. Well, I think that is a rather good statement; yes, sir. But let's be careful——

Senator DOUGLAS. What is the distinction between an optician and an optometrist?

Dr. CHAPMAN. Well, the optician does not examine the eye at all. The optician is not trained in the examination of the eye or any of its parts.

Senator DOUGLAS. You mean the optician is a technician?

Dr. CHAPMAN. He is a technician.

Senator DOUGLAS. Working under the direction of the ophthalmologist?

Dr. CHAPMAN. He might be, if he is in an ophthalmologist's office. He is also permitted to have his own establishment when he chooses but he is limited in what he can do in that establishment.

Senator DOUGLAS. Is there a connection between optometrists and opticians? Do you prescribe for opticians?

Dr. CHAPMAN. No, sir; we do not prescribe for opticians. However, if a patient requested my prescription to take to an optician to have his glasses fabricated he could certainly have it.

Senator DOUGLAS. In other words, the optician is more or less a satellite of the ophthalmologist, is that right?

Dr. CHAPMAN. Yes, he is and yet they have this interesting thing happening nationwide and that is that the relationship is not as strong as it was at one time, because the ophthalmologist is now bringing the technician into the office and doing his own dispensing.

Senator DOUGLAS. You mean he is hiring people on a salary or on a split fee basis and——

Dr. CHAPMAN. Well, he would hire them for a salary in the office as a technician to do this part of the service. Not, optometry——

Senator DOUGLAS. We have less independent practitioners and more salaried technicians.

Dr. CHAPMAN. I didn't catch the first part of your question.

Senator DOUGLAS. You see, one of the disputes is in the field of the so-called specialties. The American Medical Association does not want to have radiologists, anaesthesiologists, pathologists, and the rest become salaried employees of hospitals or operating on a percentage of hospital fees. They want to have them as independent practitioners.

Now, what I am trying to establish is whether the American Medical Association and the members of the American Medical Association are preserving the independence of the oculist or are they making the oculist increasingly a salaried technician of the ophthalmologist?

Dr. CHAPMAN. Well, not the oculist but the optician.

Senator DOUGLAS. Of course, the optician.

In other words, the optician is becoming not an independent professional but more a salaried employee of the medical profession?

Dr. CHAPMAN. I would think that is a fair statement; yes, sir.

Senator DOUGLAS. So, the medical profession does not protect the professional status of the oculist in the same way that it wishes to protect the independent medical status of the anesthesiologist, the radiologist, and the pathologist, is that right?

Dr. CHAPMAN. I think that—again we have to use optician, you used oculist——

Senator DOUGLAS. That is right.

Dr. CHAPMAN (continuing). For the record.

Senator DOUGLAS. Now——

Dr. CHAPMAN. And there is the oculist but that makes four "O's" and we think that is too many.

Senator DOUGLAS. What is the fourth "O"?

Dr. CHAPMAN. The oculist, we have about eliminated that term.

Senator DOUGLAS. Let's get the hierarchy, ophthalmologist at the top.

Dr. CHAPMAN. No, sir, we would reverse that.

[Laughter.]

Senator DOUGLAS. Well, according to the AMA. The ophthalmologist at the top.

Dr. CHAPMAN. Oh, yes.

Senator DOUGLAS. Now, the optometrist is in the bar sinister, is that right, according to the AMA?

Dr. CHAPMAN. Yes, sir.

Senator DOUGLAS. The bar sinister.

Now, you have the optician?

Dr. CHAPMAN. Well, you would actually have the oculist next.

Senator DOUGLAS. Oculist next?

Dr. CHAPMAN. Yes, sir.

Senator DOUGLAS. And then at the lowest rung of the ladder according to the AMA the optician?

Dr. CHAPMAN. Yes, sir.

Senator DOUGLAS. What is the difference between an optician and an oculist?

Dr. CHAPMAN. The oculist term has almost completely gone out of existence. It was popular at one time, and it signified a medical practitioner who did some extra work in eye training and usually he was also an eye, ear, nose and throat specialist. Many times on his door he would put the word "Oculist."

Senator DOUGLAS. He was actually below——

Dr. CHAPMAN. The ophthalmologist, because the ophthalmologist is a medical practitioner who takes extensive training in treatment and surgery of the eye and then qualifies by board action to be an ophthalmologist.

Senator DOUGLAS. In England for a long time the surgeon was socially inferior to the doctor largely because surgeons started as barbers, and I believe to this day in England a surgeon cannot be called a doctor. He is called a mister; isn't that true?

Dr. CHAPMAN. Mister, that is correct.

Senator DOUGLAS. A dentist in England is still lower in the hierarchy. A dentist in England, I think cannot be called a doctor, he is a mister.

What do you think of this elaborate hierarchy which is being developed?

Dr. CHAPMAN. What do I think of it?

Senator DOUGLAS. Yes.

Dr. CHAPMAN. Well, let me put it this way, Senator, I could give the most concise answer purely on the basis that I have never been called upon to represent my profession or to say anything about it or ask for anything from this Congress or from the State legislature or a Government agency which I considered to be unfair or improper for what I believe my profession can do, and all that we ask, as a profession is to be given an opportunity to utilize our services that we are trained to render to the American people. Any hierarchy of medicine which would subjugate that or eliminate it or take it away from the people of this Nation, we would, and have valiantly fought for many years.

Senator DOUGLAS. How many years of college training do your colleges prescribe?

Dr. CHAPMAN. The maximum is 6 years. We still have some colleges where there is a 5-year program but we are fast moving toward a 6-year program in all of them.

Senator DOUGLAS. Take a 5-year program, minimum program what does than consist of?

Dr. CHAPMAN. The minimum program of 5 years, well, it consists of 2 years of preoptometric training in a recognized university.

Senator DOUGLAS. That is generally the same as for medical schools, is it not?

Dr. CHAPMAN. Yes, generally the same.

The subjects taken are somewhat similar in matters of physiology, anatomy, the physics and the chemistries and various subjects that premedical students take. Then, in optometry school, you become more specialized in your approach and deal with the eye and all of its areas of interest.

Senator DOUGLAS. Do you have any internship required or not?

Dr. CHAPMAN. No. There are certain of our States that require an internship but it is not a general rule. Each man does have a pass a very rigid State board examination in each State. Optometry is legally instituted in all of the 50 States.

Senator DOUGLAS. How do you account for the fact that you are barred under this bill?

Dr. CHAPMAN. We feel, Senator, that unless this profession and this hope of freedom of choice, which we have expressed, is actually included in this bill, it is going to be administered by people who are medically dominated. This medical influence will be in administrative capacities, not only at the Washington level, but at the State levels as well. It is absolutely mandatory that we be fully specified as being a part of this program to the degree——

Senator DOUGLAS. Don't you trust the American Medical Association?

Senator ANDERSON. Before you answer that I will tell you there are some people who don't.

Dr. CHAPMAN. I beg your pardon.

Senator ANDERSON. I say before you answer that I can tell you that there are some people who don't.

[Laughter.]

Dr. CHAPMAN. Senator, I have never felt that I could totally trust anyone with whom I was having a rather significant difference of opinion, and yet I would point out that the field of ophthalmology and the marvelous work they do in caring for the diseased eyes and the problem eyes of this Nation, command my greatest admiration. For that I will always stand up.

Senator DOUGLAS. The Wilmer Institute at Johns Hopkins has made tremendous strides.

Dr. CHAPMAN. All over the Nation ophthalmology has made progress to the benefit of the public's eyes.

Senator DOUGLAS. In other words, you do not exclude them from your circle, but they exclude you from theirs.

Dr. CHAPMAN. To be frank, we cannot honestly exclude them from ours, and we do not know how they can exclude us from theirs. There is an insufficient number of us to do all of this work unless it is done by a half-trained technician in the office.

Senator DOUGLAS. How many ophthalmologists are there?

Dr. CHAPMAN. How many ophthalmologists? Four to five thousand ophthalmologists, I believe.

Senator DOUGLAS. Does this include the eye, ear, nose, and throat doctors?

Dr. CHAPMAN. No, sir. When I use the numbers 4,000 to 5,000, it signifies board-certified ophthalmologists who do nothing but eye treatment, eye surgery. There are other men in the medical field who do the work which you have described.

Senator DOUGLAS. That is all, Mr. Chairman.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. Well, I am not sure I am clear on all this business. What is the correct title of someone who takes a prescription for glasses and prepares the lenses?

Dr. CHAPMAN. Optician.

Senator CURTIS. He is an optician?

Dr. CHAPMAN. He is like a pharmacist, Senator Curtis. That might be the easiest way for you to tie it down. He would fill the prescriptions.

Senator CURTIS. Are opticians in any States permitted to fit people with glasses?

Dr. CHAPMAN. No, sir; not as far as I know. They cannot examine or prescribe. That is not part of their training, they are not equipped for it.

Senator CURTIS. Is it lawful any more to go into a drugstore or a dime store and try on some glasses until you find ones you can see through?

Dr. CHAPMAN. Yes, sir.

Senator CURTIS. It is?

Dr. CHAPMAN. Not in all States, but in most States it is.

Senator ANDERSON. In all States, is it not?

Dr. CHAPMAN. I do not know how many States have outlawed it completely. New Jersey just did. New York has a provision which almost eliminates the use of glazed goods, and I honestly do not know the number of States.

Senator CURTIS. Well, then, what is the correct title of someone who does not hold himself out as treating diseases of the eye, such as glaucoma and cataract and various circulatory diseases, but he has the patient look at various charts, the distance, and so on, and he decides what sort of eye prescription should be written? Who does that?

Dr. CHAPMAN. The optometrist.

Senator CURTIS. He is not permitted to practice medicine?

Dr. CHAPMAN. That is correct.

Senator CURTIS. But by his professional training and the ethics of his profession he is taught to detect, observe, and refer people who have diseased eyes?

Dr. CHAPMAN. Yes, sir.

Senator CURTIS. Does the State law require them to do that?

Dr. CHAPMAN. Now, I cannot answer that specifically, Senator. Whether it is specified in each State law, I do not know. But the law in each State describes and defines optometry and will include that matter in its description. This has been the basis of optometry from almost its inception, that he be trained as a professional man to do these things.

Senator CURTIS. Now, give me a layman's definition of the ophthalmologist.

Dr. CHAPMAN. A medical practitioner who has extended his training into the specific area of eye disease and eye surgery, and specializes in that field alone.

Senator CURTIS. And he may perform the services of an optometrist?

Dr. CHAPMAN. Yes, sir; although his training is much less than the training of an optometrist, he is also trained in this area of vision.

Senator CURTIS. Cases arise where the total problems are so interwoven that he does go ahead and do it?

Dr. CHAPMAN. Oh, yes.

Senator CURTIS. Now, if this bill passes just as the House wrote it, and I am confining this question not to children or to anyone else but to the retired people past 65, are the services of an optometrist covered?

Dr. CHAPMAN. They are covered in one portion of the bill, yes, sir; in the portion providing health services to individuals under public assistance.

May I ask, Mr. McCracken to answer that question for me?

Senator CURTIS. Yes.

Mr. MCCRACKEN. Senator, there are three places in the bill where the services of optometrists are specifically provided for. One is in the aid to the blind program——

Senator CURTIS. I am talking about medicare for the aged only. If this bill passes as the House passed it, one of the benefits available to people over 65 in part B, include going to an optometrist, having him try out various lenses until he writes a prescription. Will it include that? That is all I want to know.

Mr. MCCRACKEN. Well, the first two parts of the bill expressly exclude the services of physicians and optometrists in examining eyes for glasses.

Senator CURTIS. In other words, it is not included?

Dr. CHAPMAN. That is right.

Senator CURTIS. What is it you are recommending in regard to that?

Dr. CHAPMAN. Well, as I pointed out, Senator Curtis, I think that our recommendation in this bill, as I read it, is to make the provision that when and if at any time other vision services are to be rendered, besides those concerned with eyeglasses, that the patient shall have the freedom of choice to choose a practitioner of optometry if he so desires.

Senator CURTIS. Well, that is not my question. Here is the House bill—

Notwithstanding any other provision of this title, no payment shall be made under part A or part B for any expenses incurred for items or services—

And then it lists down as No. (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.

Now, are you opposed to that provision?

Dr. CHAPMAN. No, sir.

Senator CURTIS. You are not?

Dr. CHAPMAN. No, sir; we are not. I wish I could clear this whole——

Senator CURTIS. If you are not licensed to treat diseases of the eye, and this takes you out of the bill so far as the aged are concerned, what is it that you do want?

Dr. CHAPMAN. Let me mention this section of the testimony that under the basic and supplementary plans, for example, patients of physicians can be reimbursed for examinations ending in referral for surgical or pathological treatment of the eye, for contact lenses, for prescribing or fitting artificial eyes, and for orthoptics and visual training.

Patients of optometrists, however, will not be reimbursed for these services.

Senator CURTIS. Which ones of those services do you perform?

Dr. CHAPMAN. All of those. What we do not take care of is the surgical or pathological treatment.

Senator CURTIS. Read them off again.

Dr. CHAPMAN. Contact lenses.

Senator CURTIS. Is that just because it uses the term "eyeglasses" in the exclusion?

Senator ANDERSON. It is the same as eyeglasses.

Senator CURTIS. It says here no payment, notwithstanding any other provision, no payment shall be made for eyeglasses. Is that because there is different terminology?

Dr. CHAPMAN. Well, no, I do not think so. But, you see, if a physician examines a patient and was to refer that patient for various of the surgical, pathological, contact lenses, and various of those items, he could be reimbursed for that examination. The optometrist could not be. This is not a matter actually of including these items specifically in the care of the patient, but rather in the examination to determine these needs.

Senator CURTIS. Well, it excludes such expenses as are for routine physical checkups, eyeglasses, eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, and then it goes on to talk about hearing aids. I think that is pretty all-inclusive so far as your

contact lenses are concerned. It does not say those are denied to optometrists. It just says no payment shall be made to anybody.

Let me put it this way: The main business of an optometrist is eye examinations for prescribing, fitting, and changing eyeglasses; is that correct?

Dr. CHAPMAN. Upon the determination it is a healthy eye. That has to be included at the outset.

Senator CURTIS. That will not be reimbursed under this program, and you say you are satisfied with that.

Dr. CHAPMAN. Yes, sir.

Senator CURTIS. I cannot understand what it is that you want in there that you would be reimbursed for.

Dr. CHAPMAN. There are certain additional vision services in this bill that touch in the area of optometric care which administratively in the handling of this bill could, as we visualize, preclude the use of optometrists. There are several of these.

Senator CURTIS. I think you are precluded now on the section you have no objection to.

Dr. CHAPMAN. But there are other sections of the bill having to do, as I pointed out, having to do with the utilization of optometric schools and colleges where we seek a specific amendment. There are other places in the bill where there is a possibility of utilization of other practitioners other than optometrists, and that is why we want this language.

Senator CURTIS. You read things that are included, contact lenses. What else was included?

Dr. CHAPMAN. Well, the artificial eyes, orthoptics or visual——

Senator CURTIS. Well, do you give people artificial eyes?

Dr. CHAPMAN. Yes. That is not a common practice of optometry, but a number of our men do offer it over the country; yes, sir.

Senator CURTIS. Remove the natural eye?

Dr. CHAPMAN. Oh, no. This is only the prescribing or the fitting of an artificial eye for a patient who has had his eye removed.

Senator CURTIS. I see.

Dr. CHAPMAN. But this is not a major component of optometric practice?

Senator CURTIS. What else?

Dr. CHAPMAN. Having to do with the matter of orthoptics or visual training, which is the teaching of a pair of eyes to respond to stimuli and do a better and more efficient job of seeing.

Of course, there is another area, because in many instances optometrists are called upon to provide postcataract care for patients who have had cataract surgery. They demand and require very special lenses to produce sight again, and this is an area in which the optometrist is certainly qualified to render service, and for that reason we would seek that his services could be utilized if a patient so chose to use them.

Senator CURTIS. What else?

Dr. CHAPMAN. That is all of the list in the first two parts of the bill.

Senator CURTIS. In other words, your position, as far as the aged is concerned, is that while you recognize that benefits do not include expenses involving eyeglasses or eye examinations for the purpose of fitting or changing eyeglasses, that if the services of the optometrist

were lawfully used for any other health problem that you ought to be included.

Dr. CHAPMAN. Yes, sir.

Senator CURTIS. But it is a rather narrow field with you.

Dr. CHAPMAN. Well, no, sir; not to that degree. It does not seem quite that narrow because there are programs in this bill particularly having to do with care of children's vision where a great need has been pointed out, and in screening and caring for these youngsters optometry has a very large part to play, and we would want to be in there.

Senator CURTIS. I understand that. What I am trying to be prepared to answer is the request of the people past 65 if their eye care is included in this bill, and it appears it is not so far as eyeglasses or eye examinations for the purpose of prescribing or changing eyeglasses which, as I understand it, according to your testimony, is the principal function of an optometrist.

Dr. CHAPMAN. Yes, sir.

Senator CURTIS. Please understand me, I am not hostile to the rest of your presentation.

Dr. CHAPMAN. I understand.

Senator CURTIS. But I do think we sometimes get lost, we are laymen, in the definitions of these things.

Dr. CHAPMAN. Yes, sir; I am aware of that. It has always been a problem to describe.

Senator CURTIS. The ophthalmologists are doing a good job, the 4,000 or 5,000 you have described.

Dr. CHAPMAN. The ophthalmologists are doing a good job.

Senator CURTIS. Yes.

Dr. CHAPMAN. By and large, I think they are, in the area where they are best trained to do the job.

Senator CURTIS. In fact, some very outstanding things are happening.

Dr. CHAPMAN. No question about that; yes, sir.

Senator CURTIS. That is all.

Senator ANDERSON. I am merely going to say, Doctor, I had my first pair of glasses when I was a college student more than 50 years ago given to me by an optometrist, and I had my eyes checked a few weeks ago by a famous eye doctor who is part of Wilmer Clinic.

They both used the same devices, some of them, modified. They twirled gadgets around to see which fit my eye best. But the doctor—he may be an ophthalmologist—he takes me back to see, since I am a diabetic, whether I have diabetic extrusions, if I have glaucoma. That is the principal difference.

Dr. CHAPMAN. No, sir; it is not, because the optometrist today, Senator, would run through the same series of tests to make a determination of the same type, glaucoma testing as well as interior eye investigation or whether or not the retina would indicate diabetic extrusions or any other retinal problem.

Senator ANDERSON. Isn't that different from an optometrist of 50 years ago?

Dr. CHAPMAN. Yes, sir.

Senator ANDERSON. That is what I am trying to get to. I think maybe the laws ought to be changed as the professions change.

Dr. CHAPMAN. We are making a valiant effort in that regard.

Senator ANDERSON. The first optometrist I ever dealt with was a very fine man, a splendid person, but he made no pretense about knowing about my eye. All he did was fit me with glasses, and he did it well, I have no questions about it. But whether you go to diseases of the eye, it has been a somewhat recent development.

Dr. CHAPMAN. Somewhat recent, because of the extension of our training. You must remember that when we see the great numbers of patients that we do, it is not inaccurate to indicate that the Nation's first line of defense against blindness is in the optometrist's office. He is given the responsibility to determine whether or not this is a healthy eye, and it puts tremendous responsibility on this profession. That is what we have tried to recognize over these years, to improve the training and teaching of our people to do that.

Senator ANDERSON. That is what I would appreciate, Doctor, in your testimony, indicating that there has been a change in this last half century, that you do require 6 years of study in some States, and 5 years in others; that you do require some knowledge of the eye itself, the diseases that it might fall heir to.

Dr. CHAPMAN. Yes.

Senator DOUGLAS. The Senator from Nebraska has opened up some very interesting questions, and I would like to follow up, if I may.

If an M.D. prescribes antibiotics for an ailment, as I understand it, the cost of the antibiotics would be excluded from plan B, isn't that true?

Dr. CHAPMAN. Yes, I believe so, sir.

Senator DOUGLAS. But the service of the doctor of medicine would be recognized under plan B; isn't that correct?

Dr. CHAPMAN. Yes, sir; I believe that is correct.

Senator DOUGLAS. If this is true, and I believe it is, while the provision of glasses and other visual aids, such as contact lenses and the rest are like drugs excluded from plan B, why should the services of those who prescribe the glasses or the contact lenses be excluded from plan B? I think you give away a little too much in your replies to the Senator from Nebraska. It would seem to me that prescriptions for glasses, if carried out by competent persons such as the optometrists, should be recognized just as much as prescriptions for antibiotics.

Dr. CHAPMAN. Senator, I hope to have the opportunity, ultimately, to gather additional facts on the Senator's questions that I did not answer well because of not having a total knowledge of all of the components of this bill, so I will be able to answer him with greater——

Senator DOUGLAS. I thought you gave too much ground surely.

Senator ANDERSON. You will have an opportunity to examine your statements anyhow before the final printing.

Dr. CHAPMAN. I would hope we could further extend this privately, and I would be happy to do so. I do not want to leave any question, and I certainly do not want to give ground too freely, I assure you of that.

Senator DOUGLAS. I know you wouldn't push it, but I think you should claim the maximum amount of your desserts.

Dr. CHAPMAN. We are going to make an effort to do that.

Senator ANDERSON. Thank you very much.

Mrs. McGarry.

STATEMENT OF BARBARA D. McGARRY, EXECUTIVE DIRECTOR, THE AMERICAN PARENTS COMMITTEE, INC.

Mrs. McGARRY. Mr. Chairman, since our statement is, perhaps, overcondensed, and the total reading time is under 10 minutes, with the committee's permission I would like to read it, and then answer any questions the committee may have.

Senator ANDERSON. You may read it, Mrs. McGarry.

Mrs. McGARRY. To a national organization such as the American Parents Committee, which has devoted its 18 years of existence solely to the support of Federal legislation benefiting children, the 89th Congress has achieved outstanding advances, particularly in the field of education. In tribute to these achievements, we feel that never before has there been more significant recognition of our greatest national resource—our Nation's children.

It is with appreciative awareness of this deepening national interest that we appear before this distinguished committee today, to express the support of the American Parents Committee of the following provisions for child health and welfare, under the proposed Social Security Amendments of 1965:

Title II, section 201. Increase in maternal and child health services.

Section 202. Increase in crippled children's services.

Section 203. Training of professional personnel for crippled children.

Section 204. Payment for inpatient hospital services.

Section 205. Special project grants for health of school- and preschool children.

Section 211. Implementation of mental retardation planning.

Title IV, section 401. Public assistance amendments—Increase for AFDC program.

We are especially indebted to Dr. Martha Eliot, a member of our board of directors and former Chief of the U.S. Children's Bureau, for her constructive suggestions on many of these provisions. At our last annual board of directors meeting in January 1965, American Parents Committee Chairman George I. Hecht, Dr. Eliot, and other members discussed the prototype bill containing these provisions, subsequently incorporated into the general bill before you today. It was unanimously recommended, as our February 1965 American Parents Committee report indicates, that we support these increased authorizations for children.

Increases in the amounts authorized for maternal and child health services will, in the words of House Report 213—

> Assist the States to move toward the goal of extending such services with a view to making them reasonably available to children in all parts of the State by July 1975.

The American Parents Committee wholeheartedly supports greater implementation of these services. We concur in the House report's belief that:

> Increases in the child population and the cost of medical care, wide variations among the States in maternal and infant mortality, and the uneven distribution of basic health services indicate the need for additional Federal support in order to help States make their maternal and child health services available to children in all parts of the State.

We support the recommended increases for these services of $5 million for the fiscal year 1966, and $10 million for each fiscal year thereafter.

Section 202. Differences in the extent of crippled children's services are considerable throughout the States, and, as reported—

Indicative of the need for considerable growth of these programs in many States * * * the major reason for these deficiencies in State programs is inadequate funds.

In 1963, 375,000 children received medical services under this program, a national rate of 49 per 10,000 children under 21 years of age. State by State, however, the rate of service varies from the high of 124 per 10,000 to a low of 12. Many crippled children, or children with potentially crippling conditions, as has been brought out by previous testimony, are not receiving needed care because their individual conditions may not be included in their own State's program.

To broaden and unify the conditions under which all crippled children may receive needed treatment, the American Parents Committee supports the recommended increases in Federal participation of $5 million for fiscal year 1966 and $10 million annually thereafter.

Section 203. For the training of professional personnel for the care of crippled children, we are gratefully aware of the bill's inclusion of mentally retarded children, and those with multiple handicaps, which has not been stressed, perhaps, enough. In our support of the mental retardation amendments of 1963, we had urged the authorization of funds for training professional personnel, doctors, nurses, physiotherapists, as well as for the construction of facilities for the mentally retarded. We therefore welcome the opportunity to support the recommended authorizations of $5 million for fiscal 1957, $10 million for fiscal year 1968, and $17.5 million for each fiscal year thereafter, implementing a program of grants to institutions of higher learning for training of such professional personnel.

Section 204. Section 204, which we consider vitally important, of the bill, providing for—

payment of the reasonable cost * * * of inpatient hospital services—

under State plans for maternal and child health services and crippled children's services, is endorsed by the American Parents Committee, with our firm belief that no child should be denied needed hospitalization because of indigence.

Section 205. In a 5-year program of comprehensive health care, through special project grants for low-income school and preschool children, the bill responds to one of the greatest challenges to our national future. The safeguarding today of the physical and emotional health of our citizens of tomorrow is our greatest social security as a nation. The challenge and its proposed solution are reported as follows:

Many childhood disabling illnesses both physical and emotional have their origin in infancy or in the preschool years * * *. In school health programs, the availability of community resources to which children can be referred for diagnosis and treatment is the critical factor * * *. Your committee's proposal will make possible programs organized to make maximum use of available community medical services, and to bring about a better distribution of the low-income patient group among public and voluntary community clinics and hospitals * * *. It would reduce the numbers of children of preschool and school age who are hampered by remediable handicaps, and provide necessary

medical and dental care for children of low-income families who would not otherwise receive care.

For this program of grants to State agencies, to medical and dental schools, and to teaching hospitals, we support the recommended authorization of $15 million for fiscal 1966, $35 million for fiscal year 1967, $40 million for fiscal year 1968, $45 million for fiscal year 1969, and $50 million for fiscal year 1970, with the provision that no more than 75 percent of the cost of such grants derive from Federal funds.

Section 211. The American Parents Committee urges authorization of the recommended $2.75 million for each of the next 2 fiscal years, for the development of State plans to combat mental retardation.

Section 401. For the AFDC program under the public assistance amendments, beginning January 1, 1966, the Federal share of payments would be increased by an average of about $1.25 a month for needy children. The ceiling for this program would be raised from $30 a month to $32 a month. In the words of the committee report, We feel that, "The level of aid provided the needy justifies this modest increase."

For the privilege of presenting our views before this distinguished committee, our organization is deeply appreciative, with the hope that all American children will be the beneficiaries of this legislation.

Thank you.

Senator ANDERSON. Thank you. You recognize there may be some changes in these authorizations that you mention on the last page; for instance, $15 million for fiscal 1966, fiscal 1965 has only 45 days to run.

Mrs. MCGARRY. Yes.

Senator ANDERSON. And the bill might not be through by that time and therefore if we trimmed some of those down you and your organization would understand it?

Mrs. MCGARRY. Yes, of course it would, sir.

Senator DOUGLAS. Aside from the general questions we could ask Mrs. McGarry, I might observe that had a modest share in the development of public sentiment for and the drafting of the original Social Security Act of 1935. At that time we were reproached for advocating this program on the ground that we were lessening the responsibility which children should bear for the support of their parents in old age. The same charge is now being made against those of us who are supporting the King-Anderson bill and the present bill, that we are reducing the family solidarity and weakening the responsibility which children should have for the care of their parents.

Now I am sure it will be argued that these provisions which you advocate diminish the responsibility which parents owe to their infant children, that we are substituting State support and State aid for parental responsibility.

Now, what would be your reply to this?

Mrs. MCGARRY. Sir, this was the very topic of several hours of discussion——

Senator DOUGLAS. What was that?

Mrs. MCGARRY. This was the topic of several hours discussion yesterday evening between myself and another member of the committee. I am not authorized, of course, to speak for the committee to this point, but I think——

Senator DOUGLAS. Aren't you authorized to speak in defense of these grants for children?

Mrs. MCGARRY. Oh, yes, yes. But a personal observation I have——

Senator DOUGLAS. Yes.

Mrs. MCGARRY (continuing). Would be the result, of course, of this particular question which, perhaps, couldn't be anticipated in the report, and what I am saying is in defending our request for these authorizations, I know, our committee feels, that we have no intention whatever of supplanting parental obligation by Government support. This would not serve the ultimate purpose of the children.

Senator DOUGLAS. I know, but every time we provide a governmental support you reduce the liability of the parents to provide that support voluntarily on the basis of affection, so obviously in advocating these programs appropriations you must think that parental responsibility is not enough.

Mrs. MCGARRY. In extreme cases of emergency illness, where the families may be, perhaps, financially devastated by physical or mental disability, cases like that, emergency situations, we feel no child should be denied needed care because of the family emergencies.

Senator DOUGLAS. You would preserve this only for emergency situations?

Mrs. MCGARRY. Where the parents are unable to provide needed physical, medical care for their children.

Senator DOUGLAS. Isn't that true in a very large percentage of the cases, the poverty of the parents is such that they cannot provide adequate medical attention for their children?

Mrs. MCGARRY. I think that is exactly the purpose of these provisions. Don't you, Senator?

Senator DOUGLAS. I am trying to draw you out and give a better defense for this than you are making.

Senator ANDERSON. He is trying to get you to answer it.

Senator DOUGLAS. Isn't it true that a very large percentage of the parents are unable to make these payments?

Mrs. MCGARRY. That is under section 205.

Senator DOUGLAS. Isn't it also true that a certain percentage of the parents are unable to determine whether or not the child does need treatment; isn't that true?

Mrs. MCGARRY. You mean it is a matter of parental evaluation of the needs of the child.

Senator DOUGLAS. Ignorance. First inability on the part of the parents and, second, ignorance.

Mrs. MCGARRY. On top of which you may have apathy.

Senator DOUGLAS. What?

Mrs. MCGARRY. On top of which you may have indifference or apathy.

Senator DOUGLAS. Now you come to a third factor, indifference of the parents.

First, let us take ignorance of the parents. Isn't it true that many parents do not know of the defects of their children or do not have the knowledge to understand what these defects are? Isn't that true?

Mrs. MCGARRY. Yes; I believe it is, sir. You cannot penalize a child for his parents' ignorance.

Senator DOUGLAS. Now we come to the third, indifference of the parents or apathy of the parents.

Now, should the child be sacrificed because the parents are indifferent or apathetic toward the child?

Mrs. McGARRY. We certainly feel not.

Senator DOUGLAS. Isn't it true that the common law, while it recognizes parental duties, and that these responsibilities are the first line of defense, also holds that where the parent is delinquent in these matters it is proper for society to step in and provide this protection; isn't that true?

Mrs. McGARRY. That is correct.

Senator DOUGLAS. If the parent abuses a child, the child can be taken away from him; isn't that true?

Mrs. McGARRY. Yes, sir; in 33 States.

Senator DOUGLAS. If the parent encourages and permits the child to engage in immoral practices; what is the situation then?

Mrs. McGARRY. We have just had a case like that in my own State of Maryland.

Senator DOUGLAS. This is not used to supplant good parents or parents who can afford the services themselves or who know the difficulties to which children are exposed and are alert to them, but to the residual cases; isn't that true?

Mrs. McGARRY. I should say so; yes.

Senator DOUGLAS. Mrs. McGarry, I wish you would preach this from the housetops and not compel us to draw this from you by a long process of examination.

What is more, you come in here and advocate this, but we have to go out and face the voters. We have to go out and face the organizations in the country which are opposed to the whole program on the grounds which we have mentioned. While you, perhaps, do not want to deal with the aged, shouldn't you furnish some defense to this bill if it is passed in this form so far as it deals with children? Your work is not done when we get this measure through. A great many groups come in and urge us on, and then when the battle is going on out in the country they go off for the weekend and forget it.

This is one of the difficulties with the lobbying organizations. All they are interested in getting is a law, and not seeing that public opinion is developed to support the law.

Mrs. McGARRY. May I offer an observation, Senator?

Senator DOUGLAS. Yes, please.

Mrs. McGARRY. Two days ago I sent in the draft for publishing of our national newsletter defending these very points I have submitted for your committee's consideration this morning. It will be distributed nationally within this coming week, this very topic.

Senator DOUGLAS. Well, I am glad.

We find, for instance, with many educational associations, if I may speak very frankly, they come in and urge appropriations for Federal aid to education. Then when we go out in the country trying to defend this they are absent. In fact, I frequently see the local members of the National Education Association working against the very measures which they have supported down here; I want to say that it gets some of us a little bit fed up because we feel that many of these organizations—I do not necessarily mean you—push us to the fore, and then stand by and watch the principles which you advocate here in Washington defeated in the Nation at large and those of us who have supported these principles sacrificed and frequently stabbed in

the back by the very groups that come down here asking for the legislation. I am not giving you a lecture.

Mrs. McGARRY. I can assure you——

Senator DOUGLAS. You want to point out that you have a case, and I wish you would carry the message to the American public that these protections, in your judgment, are necessary because of the inability of some parents, a very considerable proportion, to pay, because of the ignorance of many parents, and because of the apathy or indifference of many parents.

Senator ANDERSON. Senator Douglas suggests that you shout from the house tops.

Senator DOUGLAS. That is right.

Senator ANDERSON. With that word we will adjourn until next Monday.

(Whereupon, at 12:30 p.m. the committee recessed to reconvene Monday, May 17, 1965, at 10 a.m.)

SOCIAL SECURITY

MONDAY, MAY 17, 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, Long, Douglas, Hartke, Williams, and Curtis.

Also present: Elizabeth B. Springer, chief clerk.

Senator ANDERSON. The committee will be in order.

The first witness this morning is John F. Nagle, National Federation of the Blind.

Mr. Nagle, we are very happy to have you here.

STATEMENT OF JOHN F. NAGLE, CHIEF, WASHINGTON OFFICE, NATIONAL FEDERATION OF THE BLIND

Mr. NAGLE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is John F. Nagle. I am chief of the Washington office of the National Federation of the Blind. My address is 1908 Q Street NW., Washington, D.C.

Mr. Chairman, section 309 of H.R. 6675, now pending before this committee for consideration, would make it possible for certain aged persons who have some social security coverage, but not enough to meet the minimum requirements under existing law, to establish eligibility and qualify for limited benefits under title II of the Social Security Act.

This special provision would liberalize the eligibility requirements so that certain elderly people who fail to meet the work requirements in present law could still qualify for benefits on the basis of as few as three quarters of coverage.

We approve section 309 of H.R. 6675 and the enlightened concept which this provision embodies.

We believe that the provisions of the Social Security Act must frequently be reexamined, and when special circumstances justify, when legal provision defeats program purpose and benefits are denied to certain persons economically and socially handicapped by age or disability, then the law must be changed.

Section 309 of H.R. 6675 recognizes such special circumstances and makes such a change—and, because of it, men and women now precluded from social security benefits will be able to qualify and draw benefits.

We urge this committee to also consider the special circumstances of blind persons now denied disability insurance benefits because they failed to work long enough in covered employment to meet the 20 quarters eligibility requirement.

We ask you to liberalize the disability insurance law for blind persons by providing that they may establish eligibility for benefit payments when they have worked six quarters in social security covered employment.

For this purpose we offer as an amendment to H.R. 6675 a bill—S. 1787—introduced by Senator Vance Hartke, and cosponsored by Senators Dirksen, Morton, McCarthy, Ribicoff, Curtis, and Williams, all distinguished members of this committee, and also cosponsored by 35 other equally distinguished Members of the U.S. Senate.

Mr. Chairman, S. 1787 is identical in all respects to S. 1268, which was offered by its long-time supporter, Hubert H. Humphrey, then senior Senator from Minnesota, as an amendment to H.R. 11865 on September 3, 1964, when the Senate was considering social security matters—and the Humphrey amendment was adopted by the Senate by voice vote, with the record of debate indicating no single voice raised in opposition.

But as you gentlemen well remember, Congress adjourned last year without reaching agreement on a social security bill, so the advantage gained by Senate acceptance of the bill to change the Federal disability insurance law for the benefit of blind persons was lost—and we are trying again with S. 1787.

S. 1787 would make several changes in the disability insurance law with particular reference to blind persons.

First, our amendment would incorporate in the disability insurance cash benefit provisions of the Social Security Act the definition of blindness which is generally recognized and used throughout the Nation.

This definition, already included in other Federal laws, would provide an ophthalmological standard for determining blindness; for example, blindness is central visual acuity of 20/200 or less in the better eye with correcting lenses, or visual acuity greater than 20/200 if accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20°.

Then, S. 1787 would permit a person whose visual impairment is such as to constitute blindness in accordance with the terms of this definition and has worked in social security-covered employment for six quarters to qualify for disability insurance cash benefits under the social security program, and to continue eligible for such payments so long as the disability of blindness lasts.

Mr. Chairman, the objective of S. 1787 is to make of the disability insurance program a true insurance program for the blind—for those who are now blind, for those who become blind in the future.

S. 1787 would condition the right to receive disability payments, and the right to continue to receive them, upon the existence and the continuing existence of the loss of sight.

Our amending proposal recognizes that the severest of all the consequences resulting from the occurrence of blindness in the life of a working person is not the physical loss, the physical deprivation of sight, but rather the severest loss sustained is the economic disaster which

befalls the newly blinded workman, the economic handicaps which are a consequence of blindness.

It is these consequences—the abrupt termination of weekly wages, the diminished earning power, the drastically curtailed employment opportunities open to the recently blinded person, or to the person who has lived a lifetime without sight—these, and not the physical absence of sight, convert the physical disability of blindness into the economic handicap of blindness.

S. 1787 would provide a partial solution to the financial catastrophe which results from blindness. It would provide a floor of minimum financial security for those who must learn to live again, to function without sight in a world of sight.

S. 1787, as Federal law, would reduce the competitive disadvantages of sightlessness; it would provide a continuing source of funds to meet the extra "equalizing" expenses of functioning, blind, in a sight-oriented society.

S. 1787 would be of immeasurable help to the worker suddenly confronted by the devastating effects of blindness—the discouragements of protracted unemployment, the despair of an expected lifetime of unemployment, the shocking loss of independence, the hurts and humiliations of dependency.

S. 1787 would also provide minimum income security to the employed blind person who has lived for years, or for a lifetime, without sight—for such a person must pay an extra price in dollars and cents when he works as a lawyer or piano tuner, as a teacher, salesman, or factory assembler.

Mr. Chairman, the usual blind person—with average abilities, with no particular talents or training—such a person works when he can find work, but he frequently is the victim of the inexorable law of life for the disabled person—last hired and first fired; gainfully employed, when he is employed at all, on jobs with the poorest pay, the shortest in duration—jobs which are now being rapidly automated out of existence.

For this person—the usual blind worker—the 20 quarters eligibility requirement in the disability insurance law makes the protection of disability insurance unavailable to him, and our proposed 6 quarters' requirement would be much more reasonable under the circumstances—under the special circumstances which confront such a person.

Mr. Chairman and members of the committee, we of the National Federation of the Blind believe that the social security programs which are intended to diminish the adverse economic and social consequences of advancing years or disabling impairments must never be considered fixed and inflexible in provision, for such rigidity may defeat the purpose to be served by such programs, while flexibility of approach and adjustment of provision to meet special circumstance may assure fulfillment of such purpose—the diminution of the hazards and heartaches of old age, the lessening of the discouragements and disadvantages of disability.

We ask this committee and the Congress, therefore, to liberalize the disability insurance law for blind persons, for the benefit of persons who may become blind.

Under existing law, a person must work in social security-covered employment for at least 20 quarters to establish eligiblity for disability insurance cash payments.

We ask you to approve S. 1787, to reduce this requirement to 6 quarters, in order that the benefits under the disability insurance program may be more readily available to more persons when blindness occurs; in order that blind persons, unable to meet the present requirement of employment for 5 years in covered work may be able to qualify for benefits under the disability insurance program.

Under existing law and practice, persons who are disabled and earn anything but the meagerest income are denied disability insurance payments as they are considered no longer sufficiently disabled and therefore no longer qualified.

Under existing law and regulation, it is not enough that a person is severely disabled, that he is unable to get a job because he is disabled, to qualify for disability insurance cash payments—he must establish his physical inability to do a job to qualify for such payments.

We ask you to change this, to allow persons who are disabled by blindness to qualify for disability benefits upon proof of blindness and to continue qualified so long as they remain blind; to continue qualified to receive benefits even though they are employed, even though they are earning, in order that disability insurance payments may be available to them to offset the extra "equalizing" expenses incurred in living and competing without sight in an environment geared to sight.

And now, Mr. Chairman, I would like to speak briefly of several other provisions of H.R. 6675——

Of course, the National Federation of the Blind still vigorously supports hospital insurance benefits for the aged under social security, and we endorse the provisions of H.R. 6675 which would establish such a program.

We are regretful, however, that H.R. 6675 does not extend the proposed hospital care protection to disability insurance beneficiaries.

Since their claim for payments must be based upon the existence of a medically determinable disability, they generally are in need of frequent, or even constant, medical and hospital care, whereas, men and women who reach retirement age may still be robust and well.

Disability insurance beneficiaries, therefore, have a greater need than do the elderly for a social security provided health care program.

It is our hope—when the proposed hospital benefits for the aged program has been in operation for a reasonable length of time, when experience has replaced expectation, and when demands upon the program are known and costs can be accurately determined—then, it is our hope that this committee and the Congress will consider extending the hospital benefits provisions of H.R. 6675 to include disability insurance beneficiaries.

Mr. Chairman, the National Federation of the Blind has worked, in Congress after Congress, to secure specially designated Federal funds to help the States in meeting the burdensome costs of providing the needy blind with adequate medical and hospital care.

Therefore, we vigorously endorse the provisions of H.R. 6675 which would establish a new social security title—title XIX—under which Federal money for medical and hospital bills would be made available to public assistance recipients and to the medically indigent.

We believe the proposed new title XIX is most important, for it would effectually serve to separate Federal public assistance money into two parts, one for aid, and the other for medical care.

Such separation would prevent the States from lowering their aid payments in order to match the Federal contributions for medical care.

This much-needed requirement would thus put an end to the practice of using over-larger portions of Federal matching funds in public assistance to pay for medical care, rather than to increase the monthly aid grants of unfortunate men and women in need of public help.

The National Federation of the Blind endorses the provisions of H.R. 6675, which would increase the amount of Federal participating payments in the public assistance titles of the Social Security Act.

But, Mr. Chairman, there is no requirement in the bill that this additional money be passed on to aided recipients to be available for their use in paying rent and food bills.

Section 405 of H.R. 6675—entitled "Maintenance of State Public Assistance Expenditures"—is called a pass-on requirement, but it is hardly that.

Section 405 does prevent the States from substituting the increased Federal public assistance money for State money in such programs, but it does not assure that monthly public assistance grants will be raised by the amount of the larger Federal share in such payments.

We request and urge this committee, therefore, to amend H.R. 6675 so as to require each State to increase the monthly grant of aid to every recipient by an amount equal to the Federal increase, then, the added Federal dollars will be available to the needy to meet always rising daily living costs.

The National Federation of the Blind endorses section 301 of H.R. 6675, which would increase benefit payments for retired and elderly persons under title II of the Social Security Act.

To the retired elderly, this increase will be available for them to use, if they choose to do so, to meet the costs of participation in the proposed supplementary health insurance benefits plan—which we endorse—and their already inadequate social security payments will not have to be further reduced to meet this new, though very beneficial, expense.

To the others who receive payments under social security—dependents of retired persons, disability insurance beneficiaries and their dependents—these people, too, will gain by the increased benefits payments provided for in section 301 of H.R. 6675, and because of the proposed increase, they will be able to live with a greater measure of decency, dignity, and adequacy.

I thank you, Mr. Chairman, for this opportunity to present these views.

Senator LONG (presiding). Thank you, Mr. Nagle. We will certainly consider the points you have made here.

Senator Anderson?

Senator ANDERSON. You haven't made any estimate of costs in the change of program.

For instance, on the one section alone where you would change to 20–200 yardstick as a measure of blindness, would that be rather expensive?

Mr. NAGLE. I don't know what the cost is, Senator. I presume the departmental people can supply that information to the committee. I have always considered my function to come in here and talk about a problem and to offer a solution to the problem, and it seems to me that this is my problem.

Senator ANDERSON. Then later on you suggest that they might mak hospital benefits available to the disability people whether or not the had reached 65.

Mr. NAGLE. We felt that if this bill were to go into effect, and peop' who qualified under it, under the six quarters provision, were then to go over to the old-age program at the age of 65, then it is conceivab' that because they qualify under a limited requirement that they woul not qualify for the old-age program, and, therefore, would have to terminate aid in benefits.

Therefore, this is why we continued this beyond the age of 65.

Senator ANDERSON. That is all.

Senator WILLIAMS. No questions.

Senator LONG. Thank you very much, sir.

The next witness will be Mr. J. Dewey Dorsett, American Insuranc Association.

Mr. KEATING. Mr. Chairman and members of the committee, may introduce Mr. J. Dewey Dorsett. I am appearing here for the Amer ican Insurance Association. Mr. Dorsett is the president, formerl was the chairman of the industrial commission in North Carolina which administered the workmen's compensation laws there and was the national president of the Association of Workmen's Compensatio Administrators.

Senator LONG. We are very happy to welcome you, Senator Keating and also your clients.

Mr. KEATING. I will have nothing more to say which I am sure is surprise to this committee.

Senator WILLIAMS. We are glad you are here this morning.

STATEMENT OF J. DEWEY DORSETT, PRESIDENT, AMERICA INSURANCE ASSOCIATION; ACCOMPANIED BY KENNETH B. KEATING, COUNSEL; AND ANDREW KALMYKOW, COUNSEL

Mr. DORSETT. Mr. Chairman, Senator Anderson, Senator Williams——

Senator LONG. Do you have a prepared statement?

Mr. DORSETT. Yes, sir; I do. I am acutely aware of time limitations. I prepared an eight-page statement with exhibits, which has been submitted to your committee, and I am sure that it will be incorporated into the record of these important hearings.

Senator LONG. That will be done.

Mr. DORSETT. So, instead of using 10 minutes, with your permission, I hope to use only 5 and I will summarize as briefly as I am able to do so the important points covered in the full statement.

First, as you know, the 190 insurance companies writing all lines of casualty and property insurance, including workmen's compensation, are vitally concerned in the effective operation of our State's workmen's compensation laws.

We and many others are firmly convinced that the overlap of workmen's compensation and social security benefits cannot long endure without serious damage to the State's workmen's compensation system.

As a matter of fact, I think it has the seeds of destruction in it.

This grave impact on workmen's compensation will be greatly magnified by the expansion of social security disability benefits provided for by section 303 of H.R. 6675.

Second, the history of how this overlap came about is documented in my statement.

What is the extent of the duplication that so concerns me? Again this is covered in great detail in that statement.

Senator ANDERSON. Where would it be in the statement?

Mr. DORSETT. Beg pardon?

Senator ANDERSON. Where would it be in the statement?

Mr. DORSETT. The statement, Senator Anderson, is eight pages long and I have endeavored to cover that with the figures and the exhibits, the exhibits that are attached to it.

Senator ANDERSON. I just want to see your figures as to how expensive this is.

Mr. DORSETT. Beg pardon?

Senator ANDERSON. I just want to see your figures, where are the figures that you have spoken about?

Mr. DORSETT. On page 4.

Senator ANDERSON. Thank you.

Mr. DORSETT. Some have endeavored to minimize the size of these overlaps. This is done by measuring the area of overlap in terms of total social security disability payments. We say that this is not the proper tests. It should be measured by the extent to which workmen's compensation payments are duplicated by social security disability benefits.

Using the most conservative figures we estimate that in workmen's compensation cases where payments of between $250 and $300 million will be made, there will be duplicate disability payments under social security. This is based on new cases occurring during one year and amounts to one-third of all the workmen's compensation payments for disability.

I emphasize that our figures, in my judgment, are conservative. If we use the data contained in a publication of the Social Security Administration itself, the size of this duplication might reach well over a half billion dollars.

What happens, under current benefit scales in the case of a man with a wife and two children, the combined average social security disability benefits and workmen's compensation equal or exceed take-home pay in all but one State. To me that is so fundamentally unsound that we make a great point of it.

With increased benefits under H.R. 6675 take-home pay would be exceeded in all States. This means that efforts at rehabilitation and the incentive to return to work, human nature being what it is, which are basic goals in any disability system, will be completely lost.

Discouraging and thwarting rehabilitation is bad enough, but this duplication has another equally serious and socially undesirable impact. It impairs, in my judgment, the whole workmen's compensation benefits structure. Duplication of workmen's compensation by social security destroys the incentive for our States to increase these benefits, and this inevitable consequence affects all workmen's compensation beneficiaries, whether or not they are entitled to social security benefits.

Already this has happened, and I have seen it in several States during the legislative sessions this year.

As you will find set forth in my statement, a provision precluding any duplication of benefits was contained in the social security dis-

ability law as originally enacted by the Congress. Social security spokesmen have suggested that the present problem might be cured by deducting security benefits from our workmen's compensation laws.

In my judgment, this is not the solution in terms of continuing and preserving the State's system. It is difficult to contemplate the maintenance of the whole, on proper benefit levels, State workmen's compensation systems to take care of what will eventually be a marginal area.

If workmen's compensation should be destroyed, we will move the clock back 50 years to the times when the only remedy the injured workman had was an action at law, uncertain as it was, for damages based on proven fault on the part of his employer.

Let us not overlook the tremendous contribution that insurance companies have made over the years in the field of safety.

Since the enactment of workmen's compensation law fatality rates have been reduced 77 percent, and the frequency of injury has been reduced 81 percent. This, in my judgment, is remarkable record and one which cannot be jeoparadized.

Unlike social security, insurance carriers' rates, as Senator Anderson so well knows, are geared to reflect and to reward improved experience due to effective safety work.

Now, may I close on a pleasant note.

We are pleased that H.R. 6675 recognizes the wisdom and social desirability of avoiding duplication, by providing an exception for medical care furnished under workmen's compensation laws.

Some who recognize the existence of duplication—the duplication problem—have recommended further study. We believe that known facts already amply justify restoration of the offset at the present time.

We suggested language, and I hope we have not been presumptuous in this instance for such an amendment, which could be incorporated into section 303, is attached to my prepared statement.

Should it be determined, however, that this study be undertaken, it is essential, in our opinion, that the area of overlap not be increased, pending its completion.

We respectfully urge then that section 303 of H.R. 6675 be eliminated from the bill or that the offset of workmen's compensation against social security disability benefits be restored as it was originally found years ago.

Gentlemen, I thank you very much for this privilege.

If there are any questions, I shall do my best to answer them and if I do not have the answers I am sure that Senator Keating and Mr. Kalmykow have the answers.

(The prepared statement of Mr. Dorsett follows:)

STATEMENT OF J. DEWEY DORSETT ON BEHALF OF THE AMERICAN INSURANCE ASSOCIATION

Mr. Chairman, members of the committee, my name is J. Dewey Dorsett and I live in Ridgewood, N.J. My appearance before your committee is on behalf of the American Insurance Association, of which I am president. American Insurance Association is a nonprofit organization whose headquarters are located in New York City. It is composed of 190 stock insurance companies writing all lines of casualty and property insurance, including workmen's compensation insurance, throughout the Nation.

Our member companies are vitally concerned in the effective operation of State workmen's compensation laws with respect to which they perform an essential function. It is their firm belief that the greatly increased overlap of workmen's compensation and social security benefits under the provisions of section 303 of H.R. 6675 would have serious adverse effects on the operation of the State workmen's compensation system. My remarks will be centered on this one point.

State workmen's compensation laws have protected employees and their employers for over 50 years. Last year the payment of over $1 billion in compensation for industrial injuries was incurred and another half billion dollars in medical benefits. Constantly the protection provided by these laws has been increased both in scope and amount.

Yet this progress is being halted and the whole system placed in jeopardy by the increasing encroachment of social security into the field of work injuries. H.R. 6675 increases this overlap to such an extent that, unless remedy is provided, it may cause vital injury to the whole system.

A short résumé of developments with respect to social security disability payments will shed light on the problem facing State workmen's compensation laws today. The Social Security Act enacted in 1935 contained no provisions for disability benefits. Such benefits were first provided in 1956 for persons between 50 and 64 years of age, who were permanently and totally disabled. At that time, the Congress wisely made provision for a workmen's compensation offset. By such "offset" we mean a deduction of workmen's compensation benefits from social security disability benefits. Thus, no duplication of any kind existed when disability benefits first became a part of our social security system.

In 1958, broad amendments to the Social Security Act were enacted. The 106-page bill contained a 1-line repealer of the offset provision. No adequate opportunity for hearing was given to persons interested in workmen's compensation and no opinion was expressed by such persons on this point. The bill was favorably reported on July 28, 1958, the very same day it was introduced, and passed the House on July 31. It passed the Senate on August 16, 1958, after brief hearings. The House concurred in Senate amendments on August 19 and the bill was approved on August 28.

We believe that the repeal of the offset provision at that time was primarily induced by a desire to eliminate an unrelated deduction of veterans' pensions which happened to be contained in the section. We seriously doubt whether anyone realized that the Federal Government had taken a step which could lead to the destruction of the State workmen's compensation system.

We are grateful for the opportunity at long last to state our case. Until the present hearings, to the best of our knowledge, no one interested in the field of workmen's compensation has been given the opportunity to testify at either a public or private hearing on the catastrophic effect that this duplication was having, and will have, on workmen's compensation insurance.

Originally, the area of overlap was small. Only persons between the ages of 50 and 64 who had suffered severe disabilities were eligible. Since then, the scope of duplication has steadily been extended by statutory amendment, regulation, and court decisions. In 1960, the Congress eliminated the age 50 requirement. About the same time, liberalized regulations were issued, under which not only the individual's physical condition but his education, age, and vocational background were to be taken into consideration in determining the existence of disability within the meaning of the Social Security Act (sec. 404.1502, Code of Federal Regulations). Courts likewise handed down increasingly liberalized decisions concerning the existence of disability.

As a result of these developments cases which would not have originally qualified for social security disability benefits are now granted payment. Thus we now find that in many cases where workmen's compensation administrators have found only partial disability, benefits for total disability under social security are being paid. A study by the industrial commission in Florida indicates that two-thirds of the cases where duplication occurred had been held to involve only partial disability by the commission. This has been true even where the workmen's compensation rating has been 25 or 30 percent of disability. This increasing scope of overlap has caused concern and indicated the need for remedy.

Section 305 of H.R. 6675 dramatically spotlights the critical situation for workmen's compensation. Under the bill, it will no longer be necessary to show that

disability must be of long continuation, or indefinite duration, or result in death. It will be sufficient to show that it has lasted 6 months or more. Workmen's compensation would be duplicated in such cases beginning with the end of the fifth month of disability. Thus, every workmen's compensation case where total disability lasts 6 months or more will receive duplicate payments under social security.

It is also likely that periods of disability which usually would end within the 6-month period would be extended to try to qualify for double payment. Similarly, periods of disability which normally would end after the 6-month period would probably be extended. Social security spokesmen have testified at these hearings that their past estimates of the cost of disability have proved too low by actual experience because the periods of disability have been much longer than they had anticipated. This would greatly be accentuated by the double payment.

Social security spokesmen at these hearings likewise have tried to minimize the degree of overlap by citing the proportion of workmen's compensation cases in relation to total social security disability payments. There is no question that nonoccupational disability far exceeds that due to employment, although we do believe that the figures they have given are substantially underestimated. However, this ratio is irrelevant in determining the effect on workmen's compensation. What is relevant and significant is the extent to which all workmen's compensation payments are duplicated by social security disability benefits.

We conservatively estimate that under the definition contained in section 303, workmen's compensation cases in the course of a year, with respect to which payment of between $250 to $300 million will have to be made, would qualify for duplicate disability payment by social security. This is based on an estimate of 42,000 to 47,000 new cases arising during that time. This sum amounts to one-third of all workmen's compensation payments for disability incurred during the course of a year.

It is interesting to note that the Social Security Bulletin for October 1964, page 25, contains an estimate by the Division of Research and Statistics of the Social Security Administration, that for 1963 workmen's compensation long-term disability cases amounted to 75,000. Long-term disability is there defined as total disability exceeding 6 months. This definition in substance is the same as that in section 303.

We are not certain how this figure was arrived at and therefore hesitate to translate this figure into compensation dollars. However, some idea may be gained by comparing this figure to the ones I have just quoted. It would appear to be well in excess of the half billion dollar mark. Possible duplication involving between one-third and over one-half billion of our total yearly compensation payments is to us staggering.

We believe that duplication of workmen's compensation payments to this extent would have disastrous effects.

As the tables attached to this statement indicate we find that cases where duplicate benefits are paid, in the case of a man with a wife and two children, average combined social security disability benefits and workmen's compensation equal or exceed take-home pay in all but one State. This is true even under current benefit scales. With the increased benefits provided by H.R. 6675 take-home pay would be exceeded in all States.

It can readily be appreciated that efforts at rehabilitation and the incentive to return to work are completely lost in such instances. These are the very cases where rehabilitation is most likely to achieve results and should be undertaken, but this duplication eliminates any incentive to such effort.

Discouraging rehabilitation, however, is not the only serious adverse effect of the overlap. Perhaps even more serious is its impairment of the workmen's compensation benefit structure. Duplication of workmen's compensation by social security destroys the incentive to increase State workmen's compensation benefits. This depressing effect on the benefit structure has been manifest even with respect to disabilities for which there is no duplication. Injured employees are thus penalized. For example, at the last session of the Ohio Legislature benefits were increased only for the first 12 weeks of disability. It was felt that social security disability benefits might before long be provided beyond that point. In Iowa benefits generally were increased, but not for permanent

total disability. The latter are the cases where duplication is most likely, but there would still be some who would have to rely on workmen's compensation alone. It is certain that the depressing effect on workmen's compensation benefits will be immeasurably increased should section 303 be enacted in its present form.

Social security spokesmen have suggested that if duplication is a problem social security should be deducted from workmen's compensation. The benefits payable under workmen's compensation are set by State legislatures. They do not depend on the wishes of employers or their insurance carriers. As social security expands, and the rate of expansion is increasing in recent years, the remaining margin payable under such laws may not be sufficient to justify the maintenance of a whole State workmen's compensation system to provide them. Yet it seems most improbable that social security will in the foreseeable future provide benefits in scope and amount equal to those under most workmen's compensation laws. The cost of doing so would be prohibitive. The compensation system would be destroyed without providing a satisfactory substitute. This seems patently unsound but still there is considerable pressure to take this course.

One State has already provided for such a deduction to the extent of one-half of social security benefits and employers' pensions as well. Such proposals have been seriously considered in several other States. These pressures have been relieved by the hope of Federal enactment of an offset provision. This prospect would be completely destroyed if section 303 is enacted in its present form or if the offset provision is not restored.

Many States are presently considering workmen's compensation benefit legislation. Your action on the current measure will no doubt influence the action they will take. We do not believe it is an exaggeration to say that the future of workmen's compensation rests in your hands.

If workmen's compensation should be destroyed, employers will be faced with the very substantial expense of actions at law for damages. Social security does not provide an exclusive remedy. This would give rise again to the uncertainties, expenses, and hardships, on employees as well as employers, which workmen's compensation was created to eliminate. A good workmen's compensation system is beyond question far preferable. Social security does not provide equal protection to the injured man, yet through duplication it hampers the proper development of the system that does.

Insurance companies have established over the years an outstanding record of service. It is their stock in trade. Prompt payment, rehabilitation, good medical care, full protection, all of these are provided.

Most important, however, are accomplishments in the field of safety. If compensation is destroyed employees and their employers would lose the safety service and incentive which workmen's compensation provides. Rates for the latter are geared to reflect and reward improved experience due to effective safety work. Social security contributions make no allowance for better safety. To the extent that social security encroaches into workmen's compensation to that extent is incentive for safety work reduced.

Since the enactment of workmen's compensation laws, fatality rates have been reduced by 76.9 percent and frequency of injury since 1926 by 80.9 percent. This is a remarkable record which should not be jeopardized.

We respectfully urge either that section 303 of H.R. 6675 be stricken or that the offset for workmen's compensation against social security disability benefits be restored.

We are pleased to note that in H.R. 6675 the wisdom of an offset provision is given recognition by the exception for medical care furnished under workmen's compensation laws contained in section 1862 relating to medicare. Some who recognize the existence of a duplication problem have recommended further study before taking action to eliminate it. We believe that known facts amply justify restoration of the offset. Suggested language for such an amendment is attached. However, should it be determined that this study be undertaken, we deem it most essential that the area of overlap be not increased pending its completion.

Should the broad duplication provided by the current bill be put into effect the harm to the compensation system may be irreparable.

CHART I.—*Duplication of workmen's compensation disability benefits by social security benefits in H.R. 6675.*

State	Combined workmen's compensation and social security benefits[1]	Average weekly take-home pay[2]	Workmen's compensation maximum weekly benefit[3]	Combined benefits percentage of take-home pay
Alabama	$96.62	$67.96	$38.00	142
Alaska	172.00	130.10	100.00	132
Arizona	222.10	90.06	152.50	247
Arkansas	92.05	65.16	35.00	141
California	142.00	101.21	70.00	140
Colorado	111.60	86.55	43.75	129
Connecticut	127.77	88.35	59.00	145
Delaware	118.97	79.30	60.00	144
District of Columbia	187.48	86.30	70.00	158
Florida	101.26	69.05	42.00	147
Georgia	94.97	66.74	37.00	142
Hawaii	142.85	87.11	75.00	164
Idaho	110.26	81.56	45.00	135
Illinois	122.85	86.73	55.00	142
Indiana	108.97	78.94	45.00	138
Iowa	105.60	78.08	42.00	135
Kansas	107.26	81.38	42.00	132
Kentucky	102.38	73.59	41.00	139
Louisiana	98.14	77.12	35.00	127
Maine	100.62	67.32	42.00	149
Maryland	119.43	79.58	55.00	150
Massachusets	137.18	83.50	71.00	164
Michigan	149.77	89.01	81.00	168
Minnisota	111.18	83.14	48.00	134
Mississippi	89.46	63.08	35.00	142
Missouri	111.93	79.60	47.50	141
Montana	114.31	88.08	46.00	130
Nebraska	103.60	77.76	40.00	133
Nevada	125.96	[4] 98.76	57.20	127
New Hampshire	104.72	70.40	45.00	149
New Jersey	111.55	84.68	45.00	132
New Mexico	103.77	83.61	40.00	123
New York	127.48	85.89	60.00	148
North Carolina	93.81	65.14	37.50	144
North Dakota	109.80	[4] 73.71	51.00	149
Ohio	121.78	[4] 91.68	56.00	133
Oklahoma	100.18	76.41	37.50	131
Oregon	121.29	[4] 85.81	57.69	141
Pennsylvania	118.68	83.88	47.50	135
Rhode Island	109.43	79.54	45.00	138
South Carolina	90.38	63.93	35.00	141
South Dakota	101.60	78.40	38.00	130
Tennessee	96.80	68.07	38.00	142
Texas	98.14	77.06	35.00	127
Utah	122.40	90.41	52.80	135
Vermont	103.26	69.00	44.00	150
Virginia	98.26	69.52	39.00	141
Washington	122.57	[4] 89.40	57.69	137
West Virginia	100.31	[4] 82.86	38.00	121
Wisconsin	130.18	83.50	64.00	156
Wyoming	118.81	[4] 84.37	55.38	140
Longshoremen's Act	114.67	[5]	70.00	

[1] Compensation benefits for temporary total disability payable to a worker with a wife and 2 children. Social security benefits provided in H.R. 6675 (medicare bill), pp. 164–165.

[2] Average weekly wages less Federal income and social security taxes (4 deductions). Based upon wages of employees to whom compensation paid, July 1964—National Council on Compensation Insurance.

[3] As of May 1965. Includes maximum allowance for temporary total disability for worker with a wife and 2 children. (Michigan and New York reflect benefit increases contained in bills that have passed their legislature.)

[4] Figures not available to National Council on Compensation Insurance for monopolistic State fund. Source: Production workers in manufacturing—1960 Statistical Supplement, Monthly Labor Review, pp. 33-35 (U.S. Department of Labor).

[5] Figures not available—varies in each State.

CHART II.—*Duplication of workmen's compensation disability benefits by current social security benefits*

State	Combined workmen's compensation and social security benefits [1]	Average weekly take-home pay [2]	Workmen's compensation maximum weekly benefit [3]	Combined benefits percentage of take-home pay
Alabama	$82.67	$67.96	$38.00	122
Alaska	144.67	130.10	100.00	111
Arizona	197.17	90.06	152.50	219
Arkansas	79.67	65.16	35.00	122
California	114.67	101.21	70.00	113
Colorado	88.42	86.55	48.75	102
Connecticut	103.67	88.35	59.00	117
Delaware	94.67	79.30	60.00	119
District of Columbia	114.67	86.30	70.00	133
Florida	86.67	69.05	42.00	125
Georgia	81.67	66.74	37.00	122
Hawaii	119.67	87.11	76.00	137
Idaho	89.67	81.56	45.00	110
Illinois	99.67	86.73	55.00	110
Indiana	89.67	78.94	45.00	115
Iowa	86.67	78.08	42.00	111
Kansas	86.67	81.38	42.00	106
Kentucky	85.67	73.59	41.00	116
Louisiana	79.67	77.12	35.00	103
Maine	86.67	67.32	42.00	129
Maryland	99.67	79.68	55.00	125
Massachusetts	115.67	83.50	71.00	138
Michigan	125.67	89.01	81.00	141
Minnesota	89.67	83.14	45.00	108
Mississippi	79.67	63.08	35.00	126
Missouri	97.17	79.60	47.50	116
Montana	93.67	88.06	46.00	103
Nebraska	84.67	77.76	40.00	109
Nevada	101.57	[4] 98.76	57.20	103
New Hampshire	89.67	70.40	45.00	127
New Jersey	89.67	84.68	45.00	106
New Mexico	84.67	88.61	40.00	96
New York	104.67	85.69	60.00	122
North Carolina	82.17	65.14	37.50	126
North Dakota	95.67	[4] 73.71	51.00	130
Ohio	100.67	[4] 91.68	56.00	110
Oklahoma	82.17	76.41	37.50	107
Oregon	102.36	[4] 85.81	57.69	119
Pennsylvania	92.17	83.88	47.50	110
Rhode Island	89.67	79.54	45.00	113
South Carolina	79.67	63.93	35.00	125
South Dakota	82.67	78.40	38.00	105
Tennessee	82.67	68.07	38.00	121
Texas	79.67	77.06	35.00	103
Utah	97.47	90.41	62.80	108
Vermont	88.67	69.00	44.00	128
Virginia	83.67	69.52	39.00	120
Washington	102.36	[4] 89.40	57.69	114
West Virginia	82.67	[4] 82.86	38.00	100
Wisconsin	108.67	83.50	64.00	130
Wyoming	100.05	[4] 84.37	55.38	119
Longshoremen's Act	114.67	(5)	70.00	----

[1] Compensation benefits for temporary total disability payable to a worker with a wife and 2 children. Social security benefits based upon average family monthly benefit of $193.60, or $44.67 average weekly, 25th Annual Report of Board of Trustees of Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, March 1965, p. 11 (H. Doc. No. 100, 89th Cong., 1st sess.)

[2] Average weekly wages less Federal income and social security taxes (4 deductions). Based upon wages of employees to whom compensation paid, July 1964, National Council on Compensation Insurance.

[3] As of May 1965. Includes maximum allowance for temporary total disability for worker with a wife and 2 children. (Michigan and New York reflect benefit increases contained in bills that have passed their legislatures.)

[4] Figures not available to National Council on Compensation Insurance for monopolistic State fund. Source: Production workers in manufacturing, 1960 Statistical Supplement, Monthly Labor Review, pp. 33-35 (U.S. Department of Labor).

[5] Figures not available—varies in each State.

SUGGESTED AMENDMENT TO PRESERVE STATE WORKMEN'S COMPENSATION BY RESTORING THE OFFSET

Amend title II of the Social Security Act by inserting after section 223 the following new section:

"SEC. 224. (a) If—

"(1) any individual (hereinafter in this section referred to as 'primary benficiary') is entitled to a disability insurance benefit for any month or any individual is entitled to a monthly insurance benefit under subsection (b), (c), or (d) of section 202 for any month on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits, and

"(2) it is determined that a periodic benefit is payable for such month to the primary beneficiary or to any other individual, under a workmen's compensation or occupational disease law of the United States or of a State, on account of a physical or mental impairment of the primary beneficiary,

then the total of the benefits referred to in paragraph (1) shall be reduced (but not below zero) by an amount equal to such periodic benefit or benefits for such month.

"(b) If any periodic benefit referred to in subsection (a)(2) is determined to be payable on other than a monthly basis (excluding a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments), reduction of the benefits under this section shall be made at such time or times and in such amounts as the Secretary finds will approximate, as nearly as practicable, the reduction prescribed in subsection (a).

"(c) In order to assure that the purposes of this section will be carried out, the Secretary may, as a condition to certification for payment of any monthly insurance benefit payable to an individual under this title (if it appears to him that such individual or any other individual may be eligible for a periodic benefit which would give rise to a reduction under this section), requires adequate assurance of reimbursement to the Federal Disability Insurance Trust Fund in case periodic benefits, with respect to which such a reduction should be made, become payable and such reduction is not made.

"(d) The reductions provided by this section shall not apply in any case where the primary beneficiary is entitled to disability insurance benefits on the basis of an application filed before the date of the enactment of this subsection."

Amend next to the last sentence of section 203(a) of such act by striking out "after any deductions under this section and after any deductions under section 222(b)" and inserting in lieu thereof "after any deductions under this section, after any deductions under section 222(b), and after any reduction under section 224".

Amend section 203(1) of such act to read as follows:

"CIRCUMSTANCES UNDER WHICH DEDUCTIONS AND REDUCTIONS NOT REQUIRED

"(1) In the case of any individual—

"(1) deductions by reason of the provisions of subsection (b), (c), (g), or (h) of this section, or the provisions of section 222(b), and

"(2) any reduction by reason of the provisions of section 224.

shall, notwithstanding such provisions, be made with respect to the benefits to which such individual is entitled only to the extent that such deductions and reduction reduce the total amount which would otherwise be paid, on the basis of the same wages and self-employment income, to such individual and the other individuals living in the same household."

Amend section 215(g) of such act by striking out "section 203(a)" and inserting in lieu thereof "section 203(a) and 224".

Senator LONG. Senator Anderson?

Senator ANDERSON. I have tried to find out where your figures are. Where are your figures on this overlap?

Mr. DORSETT. On the exhibits attached to the statement.

Senator ANDERSON. The Social Security Administration testified it runs about 2 percent.

Do you agree with that?

Mr. DORSETT. No, sir, we think it is higher than 2 percent, and with your permission may I——

Senator ANDERSON. Do you have figures to show that?

Mr. KALMYKOW. Mr. Chairman——

Senator ANDERSON. Do you have figures on it?

Mr. KALMYKOW. We estimate it is between 42,000 and 47,000 of our compensation cases.

Senator ANDERSON. Just let me have that again, 42,000 and what?

Mr. KALMYKOW. 47,000, that is conservative.

Senator ANDERSON. Insurance cases?

Mr. KALMYKOW. Workmen's compensation cases.

Senator ANDERSON. Have duplication?

Mr. KALMYKOW. That is right, would have under this new definition. And that represents compensation payments to us of between $250 million and $300 million, that we will have to pay in these cases.

Senator ANDERSON. I surely wish you would have some figures because I don't believe you do have.

Mr. KALMYKOW. These figures are based on the amount that our rating organization, the National Council on Compensation Insurance has to represent cases where total disability extends over a period of 6 months or more. They have to have those records for rate computations.

Senator ANDERSON. Secretary Celebrezze testified,

> 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.

That is a vast difference from yours.

Mr. KALMYKOW. He compared that figure to the total social security benefit claimants. It is recognized that occupational injuries are much lesser in number than disabilities not connected with employment, so one could have a hundred percent disabilities due to employment covered and yet compared to total social security payments this would be a limited percentage of that figure.

In other words, the important figure as far as the effect on compensation is how much of the total is affected, of the workmen's compensation total is affected, by these duplicate payments and not the percentage of total social security payments.

Senator ANDERSON. I understand that. But it is pretty hard to believe——

Mr. KALMYKOW. As a matter of fact to indicate——

Senator ANDERSON. Did the figure you used a moment ago come from the National Council on Compensation Insurance?

Mr. KALMYKOW. No, sir.

Senator ANDERSON. What did you refer to with the figures on the National Council on Compensation Insurance?

Mr. KALMYKOW. We based our estimate on figures they supplied to us.

Senator ANDERSON. That is just what I asked you and you said no. Did the figures come from the National Council on Compensation Insurance?

Mr. KALMYKOW. Yes.

Mr. DORSETT. All companies subscribe to them.

Senator ANDERSON. I will have to find out where they got their figures.

Mr. KALMYKOW. Their report is from all member companies that write workmen's compensation throughout the country so they are in position to know what the experience is and make appropriate rates to cover that.

Senator ANDERSON. They are very competent people and they estimate, do they, that between 42,000 and 47,000 cases would represent duplicate payments in this definition put into the law?

Mr. KALMYKOW. That is correct.

Senator ANDERSON. How many is it now without this definition?

Mr. KALMYKOW. Well, it is a little difficult to say. They contemplate approximately half that figure. That is a rough estimate at the present time.

Senator ANDERSON. You mean the inclusion of the new language would double the number of cases?

Mr. KALMYKOW. That is correct.

To indicate how conservative this figure is, there is a publication of the Social Security Administration in the October 1964 issue of the Social Security Bulletin that estimates long-term workmen's compensation cases at 75,000 for the year 1963.

So, that shows how conservative our estimate is. We aren't certain how they compiled that figure but we do want to cite it to indicae that our figure is a conservative one.

Senator ANDERSON. Wouldn't there be those duplicate payments then in those cases without the passage of this legislation? What does this language do to that?

Mr. KALMYKOW. No. These are the cases that refer to 6 months and more of total disability. This is equivalent to, 75,000 persons is equivalent to, the cases that would come under this new definition of 6 months and more.

Senator ANDERSON. You have a 6 months and more language now, don't you, in the law?

Mr. KALMYKOW. Not as far as the definition of disability is concerned. That is merely a waiting period provision.

Senator ANDERSON. Well, your definition of disability is very strict now. It must be something resulting in death or be permanent?

Mr. KALMYKOW. That is right.

Senator ANDERSON. It is pretty hard for a doctor to decide whether it would be permanent or not, isn't it?

Mr. KALMYKOW. We have that every day, because——

Senator ANDERSON. I find myself in a strange position. I sympathize with a great deal of what you said about section 803 generally and I think there ought to be a limitation on what could be paid.

What would your reaction be to an 85 percent limitation on what could be paid?

Mr. DORSETT. I am a liberal by nature. But I am afraid, Senator Anderson, if you do that you are going to destroy the incentive in the 50 States to upgrade their State workmen's compensation benefits—there has been great progress made, as you well know, in increasing benefits to the injured workmen. I am afraid if you do that you are going to discourage these States from doing anything at all about increasing benefits and that is the danger I see in this. As an old hand

who helped administer a law in my native North Carolina for 10 years, I don't want to see anything done that will discourage the people not only in North Carolina but New Mexico, Louisiana, Delaware, and wherever, from increasing the benefits under worymen's compensation, because I think in 50 years that system has stood the test, and has performed marvelously.

Senator ANDERSON. The figures you got from the National Council on Compensation Insurance are in your report here, are they?

Mr. KALMYKOW. Yes, they are incorporated on pages 4 and 5.

Senator ANDERSON. Pages 4 and 5 don't have any numbers in them on cases, do they?

Mr. KEATING. The top of page 5.

Mr. KALMYKOW. Top of page 5.

Senator ANDERSON. That is an estimate.

Mr. KEATING. That is right.

Senator ANDERSON. The national council gave the facts.

Mr. KEATING. That is stated as an estimate, that is right.

Senator ANDERSON. All right.

I have been hoping to get some figures on this for a long time because there must be some available statistics on it.

Mr. KALMYKOW. The reason we say it is an estimate is because it does not include any partial disability cases that may be held to constitute total disability by the Social Security Administration.

It includes only the cases where total disability has exceeded a period of 6 months or more. It includes, of course, partial disability cases which, subsequent to the period of total disability may become partial and some permanent condition may continue, but all these are cases where according to records total disability has exceeded 6 months or more.

Senator WILLIAMS. Mr. Dorsett, in line with the questioning of Senator Anderson, when the Secretary was before the committee I requested that they furnish to our committee a report similar to what you have done here showing their estimates as to how these figures would be, and I am advised by the staff as yet they have not been able to get those figures together but they will be submitting them to the committee and, Mr. Chairman, I would like to ask that they be printed at this point in the record also and I am asking Mr. Dorsett if when they are printed if there is a difference between their estimates and your estimates as included here today and you wish to comment further that you would do so.

Because I understand this is—both of you have to take some estimates into consideration, certain factors but they should be reasonably close when you finally get down to the figures, and they may be.

Mr. DORSETT. We will be glad to comment and whatever other pleasure of this committee it is.

(The information referred to follows:)

(The Commissioner of Social Security subsequently submitted the following material on this subject. This information was not received in sufficient time to allow the American Insurance Association to submit comments thereon before the hearings were sent to press.)

The table previously submitted by the Administration, which appears on page 151 of part 1, is reprinted here for comparative purposes:

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 [3]	Combined benefits percentage of take-home pay
Alabama	$83.00	$75.68	$38.00	109.7
Alaska	97.65	133.89	62.65	73.2
Arizona	111.82	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	85.90	[4] 32.21	89.9
Connecticut	102.00	97.00	57.00	105.2
Delaware	95.00	99.99	50.00	95.0
District of Columbia	112.67	90.30	67.67	124.8
Florida	87.00	79.73	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	100.0
Indiana	87.00	94.50	42.00	92.1
Iowa	82.00	84.73	37.00	96.8
Kansas	87.00	84.74	42.00	102.7
Kentucky	97.00	91.00	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
Minnesota	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	82.35	40.00	103.2
Nebraska	85.00	80.91	40.00	105.1
Nevada	96.93	102.04	51.93	95.4
New Hampshire	90.00	77.01	45.00	116.9
New Jersey	90.00	98.43	45.00	91.9
New Mexico	83.00	82.98	38.00	100.0
New York	100.00	99.97	55.00	100.0
North Carolina	92.80	79.09	37.80	117.7
North Dakota	96.00	79.21	51.00	121.2
Ohio	94.00	97.61	49.00	96.1
Oklahoma	82.80	83.11	37.80	99.5
Oregon	92.34	80.14	47.34	109.4
Pennsylvania	92.50	88.42	47.50	104.6
Rhode Island	90.00	76.50	45.00	118.1
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	115.00	(5)	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 ¼ 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. 20, 1965.

Date: May 20, 1965.
Memorandum from: Robert M. Ball, Commissioner of Social Security.
Subject: Concurrent eligibility under workmen's compensation and social security.

This memorandum is concerned with information on the extent and effects of concurrent eligibility under workmen's compensation and social security. In particular, it will comment on two tables, entitled "Duplication of Workmen's Compensation Disability Benefits by Social Security Benefits in H.R. 6675," submitted on May 17 by Mr. J. Dewey Dorsett, representing the American Insurance Association, and on a similar table submitted, at the request of Senator John J. Williams, of Delaware, by the Social Security Administration.

The table submitted by the Social Security Administration was, in accordance with Senator Williams' request, an updated and somewhat modified version of a table that the chamber of commerce had arranged to have prepared; the updated table took into account, among other things, changes that have occurred in workmen's compensation benefit levels and increases in social security benefits that would be provided in H.R. 6675. The tables prepared by Mr. Dorsett appear to be similar to the chamber of commerce table but, like the table prepared by the Social Security Administration at the request of Senator Williams, contain updated information. In all of the tables, the benefits payable under both programs (social security and workmen's compensation) to a worker with a wife and two children are compared with his take-home pay (gross wages less certain assumed income taxes and social security contributions).

The replacement percentages shown in the table updated by the Social Security Administration—that is the extent to which the assumed combination of social security disability benefits and workmen's compensation payments would replace earnings—differ from those shown in both of Mr. Dorsett's charts; and the replacement percentages shown on Mr. Dorsett's chart I differ substantially from those shown on his chart II. The differences do not stem primarily from different assumptions as to average earnings,[1] as was implied by Mr. Dorsett in his testimony before the committee; rather, in the case of both charts I and II they stem from different assumptions as to the benefits that would be payable under workmen's compensation. Moreover, the social security disability benefit amounts used in chart I differ from those used by the Social Security Administration.

It would seem appropriate to calculate social security benefits for a worker with average earnings on the basis of an average figured over the period after 1950, excluding 5 years, rather than on an average based on current earnings. The average social security benefit rate for the disabled worker families reflect generally earnings averaged over this period. The table updated by the Social Security Administration and Mr. Dorsett's chart II follow this method; they assume that the social security benefits payable to the family of a disabled worker with average earnings would be equal to the average family social security monthly disability benefit ($106). On the other hand, as far as we can determine, in chart I Mr. Dorsett computes the average social security disability benefit that would be payable to the worker's family on the basis of his most recent earnings. This results in unrealistically high social security benefits since the most recent earnings can be expected to be higher than earnings averaged over a relatively long period. Moreover, Mr. Dorsett assumes that the maximum social security disability family benefit would be $72 weekly—the maximum under H.R. 6675 based on average earnings of $5,600. This amount will not become payable until, at the earliest, 1970; even then it could be payable only in cases of workers who are disabled when they are no older than 31, and who have earned $5,600 or more in each year beginning with 1960 and up until the time their disabilities occur. (The maximum social security weekly family benefit payable in 1965 under H.R. 6675 will be $66.20.)

In the table updated by the Social Security Administration the workmen's compensation benefits that were assumed to be payable were those that would be payable for permanent total disability. Both of Mr. Dorsett's charts use as the workmen's compensation benefit the maximum workmen's compensation benefit payable for temporary total disability.

[1] Briefly the average earnings used by the Social Security Administration are the 1963 average weekly wages in employment covered by unemployment compensation. Mr. Dorsett used the July 1964 average weekly earnings paid to employees entitled to workmen's compensation. The amounts differ very little.

With respect to Mr. Dorsett's computation of the workmen's compensation benefit amounts, the following observations seem pertinent:

1. Workers who qualify under the present social security definition are much more likely to be receiving workmen's compensation based on permanent and total disability than on temporary total disability; although the picture would change somewhat if H.R. 6675 is enacted, by and large the same would be true after enactment of H.R. 6675. The maximum benefits paid for permanent and total disability are lower in some States than the maximum benefits paid for temporary total disability (for example, under the Alaska law, the maximum permanent and total disability benefit is $52.65 weekly; the maximum for temporary total disability is $100 weekly).

2. Although Mr. Dorsett assumes that the worker would be receiving maximum workmen's compensation benefits, a disabled worker with average earnings at the time of disability would be entitled to workmen's compensation benefits lower than the maximum under many State laws. For example, Mr. Dorsett assumes that a worker with take-home pay of $90 would receive an Arizona workmen's compensation benefit of $152.50—much higher than his take-home pay. Actually, the benefit for permanent and total or temporary total disability under the Arizona law amounts to 66 percent of earnings. The earnings for Arizona used in the social security table is about $101 weekly. We are not sure what earnings would be reflected by the take-home pay shown in Mr. Dorsett's charts; presumably they would also be about $101 weekly. Thus, the worker would be entitled to a workmen's compensation benefit of about $66 as shown in the Social Security Administration table, and not $152.50 as shown in Mr. Dorsett's charts. The workmen's compensation benefit shown for Hawaii in Mr. Dorsett's charts is another example. Under Hawaii law, total disability benefits amount to 60 percent of earnings. The workmen's compensation benefit based on the average earnings (less than $86) should be $58 as shown in the Social Security Administration table. Mr. Dorsett's charts show the benefit to be $75, the maximum payable under the Hawaii law for temporary total disability and for permanent total disability.

There are a number of points that should be made with respect to all of the tables—the two submitted by Mr. J. Dewey Dorsett on behalf of the American Insurance Association and the one prepared by the Social Security Administration to update the chamber of commerce table.

The most important point is that the data in the tables apply to only a small fraction of 1 percent of the people who receive either workmen's compensation or social security disability benefits. This is true for the following reasons:

1. There is but a very small overlap between workmen's compensation and social security benefits. The number of disabled worker beneficiaries under the social security program who are also receiving workmen's compensation payments represents only about 2 or, at the most, 3 percent of all workers who are receiving social security disability benefits. The reason this percentage is so small is that the disabled workers receiving benefits under the social security program are, by and large, those whose disabilities are not only total but also chronic and, in addition, not work-related, while, on the other hand, the disabled on the workmen's compensation rolls are made up primarily of people who either have total disabilities that last a relatively short period (about 98 percent less than 6 months and therefore unaffected by H.R. 6675) or have disabilities which, though permanent, are only partial and, in any case, have work-related disabilities. (See app. A and B.) The attached statement, "Estimates of the Proportion of Workers That Are Currently Entitled to Social Security Disability Benefits and Workmen's Compensation," gives additional information on the extent of the social security-workmen's compensation overlap.

2. The data in the tables apply only to disabled workers at average earnings, thus taking no account of the fact that about one-half of the workers have above-average earnings. Combined social security benefits and workmen's compensation payments would, of course, represent a smaller proportion of earnings for workers who have higher than average earnings.

3. The data in the tables are based on the assumption that the disabled worker has three eligible dependents and on the assumption that such dependents gen-

erally remain on the benefit rolls throughout the entire period of the worker's disablement. (Apps. C and D show the formulas for computing the benefits shown in the tables.) The fact is, though, that many disabled persons do not have as many as three eligible dependents and that dependents' benefits are generally payable under social security (and under those State workmen's compensation laws which provide for them) only while the worker's children (if not disabled) are under age 18 (age 22 under H.R. 6675) and unmarried.

The data in the tables also do not take into account the fact that:

1. The wages of workers who have become disabled would very likely have increased (had the workers not become disabled) about 3 percent per year on the average, even if no allowance is made for the possibility that the workers would have advanced into better paying jobs as their work careers progressed. The calculations in the table, being based on wages prior to disability, are comparing benefits with earnings the workers had in the past and not with earnings they might be expected to have currently were they not disabled.

2. No social security disability benefit is paid in the first 6 months of disablement, workmen's compensation laws in many States have maximum dollar or duration limits, and some workmen's compensation laws reduce disability benefits after a specified duration. The computations in the table are based on a single month in which both workmen's compensation and social security disability benefits happen to be payable—a month in which the worker's benefits are highest under both programs. Calculations over the period of the disability would, of course, show much different results with respect to the replacement of prior earnings than the results shown on the tables. (See app. E.)

3. Many workers, had they continued to be employed rather than becoming disabled, would have fringe benefits. In suggesting the proportion of earnings that combined social security benefits and workmen's compensation would replace, the tables ignore the value of fringe benefits.

Attachments.

APPENDIXES

Appendix A. A copy of a tabulation of distribution of workmen's compensation awards for 1955–61 by year and type. (Source: National Council on Compensation Insurance.) This material shows that out of about 650,000 workmen's compensation awards each year between 500 and 600 were for permanent total disability (including permanent partial disability of 75 percent or more of total). Major permanent partial awards (25 to 75 percent of total) amounted to between 15,500 and 17,500, with temporary total awards accounting for almost three-fourths of the total number of awards.

Appendix B. A copy of a tabulation of the distribution of workmen's compensation temporary total awards by duration of disability. (Source: Fratello, "Workmen's Compensation Injury Table" and "Standard Wage Distribution Table," in Proceedings of the Casualty Actuarial Society, vol. 42, p. 140.) This tabulation shows the distribution of temporary total disability awards under the State workmen's compensation laws in 1951 by duration of disability. Of 68,944 awards, only 842 had disabilities lasting more than 175 days.

Appendix C. A copy of a tabulation showing benefit rates and minimum and maximum benefits for permanent and total disability under the workmen's compensation programs. This material indicates the workmen's compensation dollar maximums in weekly benefits in the various State and the States where there were limits on the duration or total benefit payments or both. (Source: Bull. No. 161, revised September 1964, Department of Labor, Bureau of Labor Standards, table 10.)

Appendix D. A copy of a similar tabulation showing benefit rates and minimum and maximum benefits for temporary total disability under the workmen's compensation programs. (Source: Bull. No. 161, revised September 1964, Department of Labor, Bureau of Labor Standards, table 7.)

Appendix E. A tabulation of estimated illustrations of earnings replacement by workmen's compensation and social security benefits from date of injury to age 65.

APPENDIX A

Workmen's compensation awards—41 States and District of Columbia by year and type[1]

Policy year[2]	Death		Permanent and total disability[3]		Major[4] permanent partial disability		Minor[5] permanent partial disability		Temporary total disability		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1955–56	5,196	0.79	522	0.08	16,675	2.55	153,427	23.42	479,242	73.16	655,067	100
1956–57	5,312	.80	636	.10	16,872	2.53	163,781	24.52	481,320	72.06	667,921	100
1957–58	5,336	.82	492	.08	15,661	2.40	162,274	24.89	468,188	71.81	651,901	100
1958–59	5,070	.78	503	.08	16,515	2.53	161,881	24.76	469,845	71.86	653,814	100
1960–61	5,152	.79	603	.09	17,403	2.67	162,616	24.89	467,593	71.56	653,427	100
1955–59 and 1960–61	26,066	.79	2,756	.08	83,186	2.53	803,979	24.50	2,366,188	72.09	3,282,125	100

[1] Because in some cases a permanent and total disability may be classified initially as temporary total and because some workers entitled to workmen's compensation may have some impairments that are compensable and some that are not compensable under workmen's compensation, a small proportion of the workers whose disabilities are classified under workmen's compensation as permanent partial or temporary total may qualify for social security disability payments.

[2] Policy year 1959–60 omitted because summaries for that year have not been made available. It is believed that the distribution of awards in 1959–60 does not differ significantly from that in the years listed above.

[3] Permanent disabilities rated at 75 to 100 percent of total.

[4] "Major permanent" means permanent partial disabilities having severity equivalent to approximately 25 to 75 percent of total.

[5] "Minor permanent" means permanent partial disabilities having severity equivalent to less than approximately 25 percent of total disability.

Source: National Council on Compensation Insurance.

APPENDIX B

Workmen's compensation injury table—Exhibit E–VI

Duration (days)	Commutation columns			Duration (days)	Temporary total disability		
	Number of cases	Summary of col. (2) upward	Days' disability lasting col. (1) and over		Number of cases	Summary of col. (2) upward	Days' disability lasting col. (1) and over
(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)
1	(5,654)	68,944	1,578,486	41	205	10,253	562,110
2	(5,457)	62,990	1,509,542	42	714	10,048	551,848
3	(4,891)	57,540	1,446,552	43 to 49	1,861	9,334	520,543–468,411
4	(4,273)	52,642	1,389,012	50 to 56	1,552	7,473	460,484–418,447
5	(3,972)	48,422	1,336,370	57 to 63	1,134	5,921	412,009–378,857
6	(2,854)	44,450	1,287,948	64 to 70	779	4,787	378,760–346,649
7	2,926	41,596	1,243,498	71 to 77	555	4,008	342,306–319,261
8	2,011	38,670	1,201,902	78 to 84	500	3,453	315,670–295,639
9	1,919	36,659	1,163,232	85 to 91	365	2,953	292,700–275,658
10	1,968	34,740	1,126,573	92 to 98	344	2,598	272,963–258,018
11	1,796	32,772	1,091,833	99 to 105	262	2,254	255,652–242,639
12	1,495	30,976	1,059,061	106 to 112	207	1,992	240,572–228,992
13	1,199	29,481	1,028,085	113 to 119	176	1,785	227,187–216,758
14	2,357	28,282	998,604	120 to 126	148	1,609	215,091–205,708
15	1,123	25,925	970,322	127 to 133	130	1,461	204,197–195,681
16	1,067	24,802	944,397	134 to 140	120	1,331	194,311–186,481
17	1,106	23,735	919,595	141 to 147	103	1,211	185,212–178,117
18	961	22,629	895,860	148 to 154	80	1,108	176,974–170,487
19	820	21,668	873,231	155 to 161	70	1,028	169,434–163,393
20	648	20,848	851,563	162 to 168	64	958	162,410–156,753
21	1,365	20,200	830,715	169 to 175	52	894	155,830–150,537
22	670	18,835	810,515	176 to 182	61	842	149,669–144,710
23	627	18,265	791,680	183 to 189	46	781	143,906–139,318
24	566	17,638	773,415	190 to 196	55	735	138,566–134,241
25	528	17,072	755,777	197 to 203	38	680	133,541–129,526
26	450	16,544	738,705	204 to 210	42	642	128,875–125,107
27	369	16,065	722,161	211 to 217	33	600	124,490–120,933
28	1,028	15,716	706,076	218 to 224	44	567	120,848–117,037
29	403	14,688	690,360	225 to 231	23	523	116,501–113,403
30	470	14,285	675,672	232 to 266	121	500	112,897– 96,060
31	407	13,815	661,387	267 to 301	67	379	97,675– 86,058
32	436	13,408	647,572	302 to 336	54	312	85,742– 75,896
33	378	12,972	634,164	337 to 371	50	258	75,532– 67,626
34	244	12,594	621,192	372 to 406	22	208	67,414– 60,679
35	686	12,350	608,598	407 to 441	19	186	60,491– 54,350
36	286	11,664	596,248	442 to 476	24	167	54,211– 48,903
37	282	11,378	584,584	477 to 511	24	143	48,760– 44,264
38	334	11,096	573,206	512 to 581	24	119	44,144– 36,603
39	258	10,762	540,844	582 to 651	27	95	36,597– 31,127
40	251	10,504	530,591	652 and over	.....	68	31,059–

TABLE 10.—*Minimum and maximum benefits for permanent total disability*

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
Alabama	[1] 55–65	400 weeks. (For specific types of disability, 500 weeks.)	$15, or actual wage if less	$38	$15,200
Alaska	65	Duration of disability	$18, or actual wage if less	$52.65	
Arizona	65	Life	$20 if worker is 21 years of age or older	$150	
Arkansas	65	450 weeks	$7	$35	12,500
California	[2] 61⅔	400 weeks: thereafter 60 percent of average weekly earnings at time of injury, for life.	$20	$52.50	
Colorado	66⅔	Life [3]	$10 [3]	$43.75 [3]	([3])
Connecticut	60	Duration of disability	$20	55 percent of State's average production wage ($57).	
Delaware	66⅔	do	$25, or actual wage if less	$50	
District of Columbia	66⅔	do	$18, or average wage if less	$70	
Florida	60	do	$8, or actual wage if less	$42	
Georgia	60	400 weeks	$12, or actual wage if less	$37	12,500
Hawaii	66⅔	Duration of disability	$18	$75	([4])
Idaho	[1] 55–60	400 weeks: [5] thereafter $15 per week ($18 if dependent wife) plus $4 to $15 for children, for duration of disability.	$15 ($18 if dependent wife) to $33 [1]	$32 to $52 [1] (see col. 3)	
Illinois	[1] 65–80	Life	$31.50 to $49 [1]	$51 to $61	([6])
Indiana	60	500 weeks; thereafter payments may be made for an indefinite period. [7]	$18	$42	[7] 16,500
Iowa	66⅔	500 weeks	$18	$37	18,500
Kansas	60	415 weeks	$7	$42	17,430
Kentucky	66⅔	425 weeks [8]	25 percent of 85 percent of the State's average weekly wage.	55 percent of 85 percent of the State's average weekly wage.	
Louisiana	65	400 weeks	$10, or actual wage if less	$35	
Maine	66⅔	500 weeks	$18	$42	21,000
Maryland	66⅔	Duration of disability [9]	$18, or average wage if less	$48	30,000
Massachusetts	66⅔	do [9]	$20	$53, plus $6 for each total dependent; aggregate shall not exceed the average weekly wage of the employee.	
Michigan	66⅔	do [10]	$18 to $23 [1]	$33 to $57 [1]	
Minnesota	66⅔	do	$17.50, or actual wage if less	$45	([11])
Mississippi	66⅔	450 weeks	$10	$35	12,500

See footnotes at end of table, p. 911.

TABLE 10.—*Minimum and maximum benefits for permanent total disability*—Continued

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
Missouri	66⅔	300 weeks, thereafter 40 percent of wages, maximum $27.50 for duration of disability.	$16	$42.50	
Montana	[1] 50–66⅔	500 weeks	$25.50	$29 to $50 [1]	
Nebraska	66⅔	300 weeks; thereafter 45 percent of wages, maximum $32 for duration of disability.	$26 or actual wage if less, first 300 weeks; thereafter $22 or actual wage if less.	$40 (see col. 3)	
Nevada		Life	$37.50 to $51.92 [1]	$37.50 to $51.92 [1]	
New Hampshire	66⅔	312 weeks; thereafter annual extensions in the discretion of the labor commissioner.	$15, or actual wage if less	$45	
New Jersey	([12])	450 weeks; under certain conditions benefits paid for life.[13]	$10; after 450 weeks may be $5 [12]	$45 [12]	
New Mexico	60	500 weeks	$24, or actual wage if less	$38	$20,000
New York	66⅔	Duration of disability	$20, or actual wage if less	$55	
North Carolina	60	400 weeks; 500 weeks for 2 injuries in same employment (payable for life in certain circumstances.[13]	$10	$37.50	[13] 12,000
North Dakota	60	Life	$15, plus $3 for each dependent child under 18, or those 18 and over incapable of self-support (up to a total of $15).	45 to $60 [1]	
Ohio	66⅔	do	$40.25,[14] or average wage if less	$49	
Oklahoma	66⅔	500 weeks	$15, or actual wage if less	$37.50	
Oregon		Duration of disability	$28.85 to $63.46 [1]	$28.85 to $63.46 [1]	
Pennsylvania	66⅔	do	$27.50, or 90 percent of actual wage if less, but in no event less than $20.	$47.50	
Puerto Rico	66⅔	do	$9.23	$20.76	
Rhode Island	60	Duration of disability [15]	$17 if worker is receiving benefits under the Temporary Disability Insurance Act; $22 if worker is not receiving benefits under the Temporary Disability Insurance Act.	$40 if worker is receiving benefits under the Temporary Disability Insurance Act; $45 if worker is not receiving benefits under the Temporary Disability Insurance Act.	([15])
South Carolina	60	500 weeks	$5	$35	10,000
South Dakota	55	300 weeks; thereafter 30 percent of earnings, maximum $15 for life.	$20, first 300 weeks; $12 thereafter	$38 (see col. 3)	13,500
Tennessee	65	550 weeks	$15, or average wage if less, but in no event less than $12.	$36	14,000
Texas	60	401 weeks	$9	$35	

Utah	60	200 weeks; thereafter 45 percent of weekly wages during disability, maximum $40.[16]	$25 to $39.25 [1]	$40 to $54.25 [1]	[16]
Vermont	66⅔	330 weeks [2]	$20, plus $2.50 for each dependent child under 21, or average wage if less.	$39, plus $2.50 for each dependent child under 21.	12,870
Virginia	60	500 weeks	$14	$39	15,600
Washington		Duration of disability	$38.08 to $71.54 [1]	$38.08 to $71.54 [1]	
West Virginia	66⅔	Life	$22	$38	
Wisconsin	70	do	$14	$64	
Wyoming			$28.85 to $34.62,[1] plus $5.54 for each dependent child under 18, or each child under 21 incapable of self-support because of mental or physical incapacity.[17]	$28.85 to $34.62,[1] plus $5.54 for each dependent child under 18, or each child under 21 incapable of self-support because of mental or physical incapacity.[17]	[17] 12,000 19,000
United States:					
Federal employees	[1] 66⅔-75	Life	$41.54, or actual wage if less	$121.15	
Longshoremen	66⅔	Duration of disability	$18, or average wage if less	$70	

[1] According to number of dependents. In Idaho, Oregon, Washington, and Wyoming according to marital status and number of dependents. Under the Federal Employees' Compensation Act, the 75 percent of wages is contingent upon the existence of a statutory dependent.

[2] The California law provides for 55 percent of 95 percent of actual earnings, or 61¾ percent.

[3] Colorado: If periodic disability benefits are payable to the worker under the Federal OASDI, the workmen's compensation weekly benefits shall be reduced (but not below zero) by an amount approximating one-half such Federal benefits for such week. If disability benefits are payable under an employer pension plan, the workmen's compensation benefits shall be reduced in an amount proportional to the employer's percentage of total contributions to the plan.

Colorado does not limit total maximum for disability from accidental injury, but sets a maximum of $12,598.25 in case of occupational diseases.

[4] Hawaii: After $25,000 has been paid, compensation at the same rate is paid form a special fund.

[5] In case total disability begins after a period of partial disability, the period of partial disability shall be deducted from the weeks specified.

[6] Illinois: After $13,500 to $17,500, depending upon number of dependents, has been paid, a pension for life is provided.

[7] Indiana: After $16,500 and 500 weeks, further payments of compensation may be paid for an indefinite period from a special fund.

[8] Kentucky: If period of total disability begins after a period of partial disability, the period of partial disability shall be deducted from the 425 weeks.

[9] Law expressly provides that such payments are in addition to payments for temporary total.

[10] Michigan: Law states that there is a conclusive presumption that disability does not extend beyond 800 weeks, but after that time the question of permanent total disability is determined in each case in accordance with the facts.

[11] Minnesota: After $18,000 paid, OASDI benefits credited against workmen's compensation benefits.

[12] New Jersey: Benefits set in accordance with a "wage and compensation schedule." After 450 weeks, if worker has accepted such rehabilitation as may have been ordered by the Rehabilitation Commission, further benefits may be paid during disability, amounting to his previous weekly compensation payment diminished proportionately as the wages he is then able to earn bear to the wages received at the time of the accident. If his wages equal or exceed such former wages, his benefit rate shall be reduced to $5 a week.

[13] North Carolina: In cases in which total and permanent disability results from paralysis resulting from an injury to the brain or spinal cord or from loss of mental capacity resulting from an injury to the brain, compensation shall be paid during the life of the injured employee, without regard to the 400 weeks or to the $12,000 maximum.

[14] Ohio: For persons previously awarded permanent total disability benefits, supplemental payments may be made from the disabled workmen's relief Fund to bring payment up to $40.25.

[15] Rhode Island: After 1,000 weeks, or after payment of $16,000, payments to be made for life from second-injury fund.

[16] Utah: After payment of $15,800 by the employer or carrier, a worker who has cooperated with the Division of Vocational Rehabilitation but who cannot be rehabilitated receives from the combined injury fund 45 percent of wages, for period of disability, weekly maximum $40.

[17] Wyoming: As to the allowance for the children, the law states: "* * * there shall be credited to the account of each of such children * * * a lump-sum equivalent to $24 per month ($5.54 per week) until the time when each of said children would become 18 years of age; provided that the lump sum credited to the account of all said children shall in no case exceed $7,000." The total maximum of $19,000 shown on the table includes the $7,000.

APPENDIX D

TEMPORARY TOTAL DISABILITY

The great majority of cases for which cash benefits are paid involve temporary total disability; that is, the employee is unable to work at all while he is recovering from the injury, but he is expected to recover fully. The disability ends with the recovery of the injured person and his return to work. Table 7, relating to benefits for such disability, shows the maximum percentage of wages used in computing benefits, and the maximum period for which benefits are paid. It shows also the minimum and maximum payments per week, as well as the total maximum amounts where these are expressly stated in the laws.

The amount of benefits in most of these laws is based on a percentage of the worker's wages, usually 60, 65, or 66⅔ percent. As to monetary amounts, these are increased in many States every legislative session. For instance, in 1963, 22 States raised benefits for temporary total disability.

As of September 1957, 12 laws provided for maximum payments of $50 or over (including dependents' allowances); by April 1960 this number had grown to 19; and by September 1964 to 26—the two Federal laws and the following jurisdictions:

Alaska	Illinois	Ohio
Arizona	Iowa	Oregon
California	Massachusetts	Rhode Island
Connecticut	Michigan	Utah
Delaware	Montana	Vermont
District of Columbia	Nevada	Washington
Hawaii	New York	Wisconsin
Idaho	North Dakota	Wyoming

TABLE 7.—*Minimum and maximum benefits for temporary total disability*

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
Alabama	[1] 55-65	300 weeks	$15, or average wage if less.	$38	
Alaska	65	Duration of disability.	$25, or average wage if less.	$100	$20,000.
Arizona	65	433 weeks	$30 if worker is 21 years of age or over.	$150, plus $2.30 for total dependents.	
Arkansas	65	450 weeks	$7	$35	$12,500.
California	[2] 61¼	240 weeks	$25	$70	
Colorado	66⅔	Duration of disability.	$10	$43.75 [3]	(3).
Connecticut	60	do	$20	55 percent of State's average production wage.[4]	
Delaware	66⅔	Duration of disability.	$25, or actual wage if less.	$50	
District of Columbia	66⅔	do	$18, or average wage if less.	$70	$24,000.
Florida	60	350 weeks	$8, or actual wage if less.	$42	
Georgia	60	400 weeks	$12, or actual wage if less.	$37	$12,500.
Hawaii	66⅔	Duration of disability.	$18, or average wage if less.	$75	$25,000.
Idaho	[1] 55-60	400 weeks;[1] thereafter $15 per week ($18 if dependent wife) plus $4 to $15 for children, for duration of disability.	$15 ($18 if dependent wife) to $33.[1]	$32 to $52 [1] (see col. 3).	
Illinois	[1] 65-80	Duration of disability until equivalent of death benefit is paid, except in specific injury cases limited to 64 weeks.	$31.50 to $49 [1]	$51 to $61 [1]	$13,500-$17,500.[1]

See footnotes at end of table, p. 914.

TABLE 7.—*Minimum and maximum benefits for temporary total disability*—Con.

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
Indiana	60	500 weeks	$18	$42	$16,500.
Iowa	66⅔	300 weeks	$18, or actual wage if less.	$34 to $50 [1]	
Kansas	60	415 weeks	$7	$42	$17,430.
Kentucky	66⅔	425 weeks [5]	25 percent of 85 percent of the State's average weekly wage.	85 percent of 85 percent of the State's average weekly wage.	
Louisiana	65	300 weeks	$10, or actual wage if less.	$35	
Maine	66⅔	500 weeks	$18	$42	$21,000.
Maryland	66⅔	208 weeks	$18 or actual wage if less.	$48	
Massachusetts	66⅔	Duration of disability.	$20, or average wage if less, but not less than $10 if normal working hours are 15 or more.	$53, plus $6 for each total dependent. Aggregate shall not exceed the average weekly wage of the employee.	$16,000, plus dependents' allowances.[8]
Michigan	66⅔	500 weeks	$18 to $28 [1]	$33 to $57 [1]	(7).
Minnesota	66⅔	350 weeks	$17.50	$45	
Mississippi	66⅔	450 weeks	$10	$35	$12,500.
Missouri	66⅔	400 weeks	$16, or actual wage if less.	$47.50	
Montana	[1] 50–66⅔	300 weeks	$25.50	$20 to $50 [1]	
Nebraska	66⅔	300 weeks [5]; thereafter 45 percent of wages, maximum $32.	$26, or actual wage if less, first 300 weeks; thereafter $22, or actual wage if less.	$40 (see col. 3)	
Nevada	[1] 65–90	433 weeks	No statutory minimum.	$45 to $62.31 [1]	
New Hampshire	66⅔	312 weeks; thereafter annual extensions in the discretion of the labor commissioner.	$15, or average wage if less.	$45	
New Jersey	(3)	300 weeks	$10	$45	
New Mexico	60	500 weeks	$24, or actual wage if less.	$38	$20,000.
New York	66⅔	Duration of disability.	$20, or actual wage if less.	$55	$6,500.
North Carolina	60	400 weeks [1]	$10	$37.50	$12,000.[1]
North Dakota	80	Duration of disability.	$15, plus $3 for each dependent child under 18, or those over 18 incapable of self-support.	$45 to $60 [1]	
Ohio	66⅔	do	$25, or actual wage if less.	$56 for the 1st 12 weeks; thereafter $49.	$10,750.
Oklahoma	66⅔	300 weeks; may be extended to 500 weeks.	$15, or actual wage if less.	$37.50	
Oregon	[1] 50–75	Duration of disability.	$30, or actual wage if less.	$32.31 to $66.92 [1]	
Pennsylvania	66⅔	do	$27.50, or 90 percent of actual wage if less, but in no event less less than $20.	$47.50	
Puerto Rico	66⅔	312 weeks	$8	$35	
Rhode Island	60	Duration of disability.[10]	$17 if worker is receiving benefits under the State temporary disability insurance act; $22 if worker is not receiving benefits under the State temporary disability insurance act.	$40 if worker is receiving benefits under the State temporary disability insurance act; $45 to $57 [1] if worker is not receiving benefits under the State temporary disability insurance act.	(10).

See footnotes at end of table, p. 914.

TABLE 7.—*Minimum and maximum benefits for temporary total disability*—Con.

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
South Carolina	60	500 weeks	$5	$35	$10,000.
South Dakota	55	312 weeks	$20 or average wage if less.	$38	$13,500.
Tennessee	65	300 weeks	$15 or average wage if less, but in no event less than $12.	$36	
Texas	60	401 weeks	$9	$35	
Utah	60	312 weeks	$25 to $39.25,[1] or actual wage if less.	$40 to $54.25 [1]	$11,204-$15,126.[1]
Vermont	66⅔	330 weeks [4]	$20 plus $2.50 for each dependent child under 21, or average wage if less.	$30, plus $2.50 for each dependent child under 21.	
Virginia	60	500 weeks	$14	$39	$15,600.
Washington		Duration of disability.	Same as maximum.	$38.08 to $71.54 [1]	
West Virginia	66⅔	208 weeks	$22	$38	
Wisconsin	70	Duration of disability.	$8.75	$64	
Wyoming	66⅔	do	$30 to $46.15 [1]	$40.38 to $60 [1]	
United States:					
Federal employees.	[1] 66⅔-75	do	$41.54, or actual wage if less.	$121.15	
Longshoremen.	66⅔	do	$13 or average wage if less.	$70	$24,000.

[1] According to number of dependents. In Idaho, Oregon, Washington, and Wyoming, according to marital status and number of dependents. In Illinois, according to number of dependent children under 16, or under 18 when not emancipated.

[2] The California law provides for 65 percent of 95 percent of actual earnings, or 61¾ percent.

[3] Colorado: If periodic disability benefits are payable to the worker under the Federal OASDI, the workmen's compensation weekly benefits shall be reduced (but not below zero) by an amount approximating ½ such Federal benefits for such week. If disability benefits are payable under an employer pension plan, the workmen's compensation benefits shall be reduced in an amount proportional to the employer's percentage of total contributions to the plan. Colorado does not limit total maximum for disability from accidental injury, except that if payable in lump sum, maximum is $13,650; in case of occupational diseases the maximum is $13,693.75.

[4] Connecticut: Beginning October 1963, the maximum amounted to $57 a week.

[5] In case total disability begins after a period of partial disability, the period of partial disability shall be deducted from the specified period for temporary total.

[6] Massachusetts: Maximum $18,000 for temporary total and permanent partial disability.

[7] Michigan: Total maximum may not exceed 500 times total weekly amount payable.

[8] New Jersey: Benefits are set in accordance with a "wage and compensation schedule." Under this schedule, the 66⅔ percent level is adhered to fairly closely for workers earning wages of $45 a week or less. For workers who earn more, the schedule specifies benefits which are less than 66⅔ percent. For instance, a worker earning $60 a week is entitled to a compensation benefit of $36, or 60 percent.

[9] North Carolina: The 400 weeks and $12,000 do not apply in cases of permanent total disability resulting from an injury to the brain or spinal cord or from loss of mental capacity caused by an injury to the brain

[10] Rhode Island: After 1,000 weeks, or after $16,000 has been paid, payments to be made from second-injury fund for period of disability. The allowance of up to $12 a week for dependent children is also payable from this fund.

Rhode Island is included on the above list, but the maximum of $57 is payable only if the worker is not receiving benefits under the State temporary disability insurance law; otherwise the maximum is $40. Ohio pays a maximum of $56 for the first 12 weeks, but drops to $49 thereafter.

Under 13 laws, the maximums range from $40 to under $50; while the remaining 15 still set maximums of under $40 a week.

Most of the laws limit the period during which temporary total benefits may be paid; this ranges from 208 to 500 weeks. There is a growing trend, however, toward paying benefits for the entire period of disability with no limitation on

the amount, and the following 18 States as well as the Federal Employees' Act now contain such provisions:

Colorado (however, compensation for occupational diseases limited to $13,693.75
Connecticut
Delaware
Idaho
Nebraska
New Hampshire (after the first 312 weeks, annual extensions may be authorized)
North Dakota
Oregon
Pennsylvania
Rhode Island
Washington
Wisconsin
Wyoming

Seven other laws, those of Alaska, the District of Columbia, Hawaii, Massachusetts, New York, Ohio, and the Longshoremen's Act specify payments of benefits for the entire period of disability, but set a maximum monetary limitation.

Injured persons who are compensated for temporary total disability may receive additional benefits for dependent children in 16 States.

APPENDIX E

ESTIMATED ILLUSTRATIONS OF EARNINGS REPLACEMENT BY WORKMEN'S COMPENSATION AND SOCIAL SECURITY BENEFITS FROM DATE OF INJURY TO AGE 65, BY STATE

The following tabulations illustrate the earnings replacement provided by benefits payable concurrently under workmen's compensation and the social security disability insurance program on a State-by-State basis from the date of injury to age 65, for workers with and without dependents, assuming average earnings in the State, below average earnings, and above average earnings.

Generally, as these tabulations show, workers with lower than average earnings are likely to receive a larger earnings replacement than those with average or higher than average earnings. The reason is that the benefits payable under the social security disability provisions are weighted to favor workers with low earnings, and workmen's compensation provisions accomplish the same result through benefit maximums and minimums and limitations on the duration and amounts payable. Social security and certain workmen's compensation laws also provide dependents' benefits for wives and minor children; these benefits may terminate when the children reach a specified age—age 18 for social security and some workmen's compensation beneficiaries.

The tabulation shown below understate the earnings that the workers would have received to age 65 had he not been disabled by not allowing for the increases in earnings that they might reasonably be expected to have had over the period of disability. A 3-percent annual increase in earnings, for example, would result in total earnings over a 15-year period about one-fourth higher than the figure shown in the tabulation. In addition social security benefits were computed on the basis of last rather than average earnings and this also tends to overstate the replacement. Offsetting this in part, the tabulations do not take into account the 7-percent increase in benefits proposed in H.R. 6675 nor any future increases in social security benefits that would be likely to be provided during the period of disability. (Periodic benefits under workmen's compensation are not generally raised for persons on the rolls.) If these benefit increases are taken into account there would be about 15-percent increase in the worker's social security benefits over the same 15-year period. On balance, therefore, on realistic assumptions, the tabulation significantly overstates the replacement value provided over the workers period of disability by benefits under both programs.

Nevertheless, the calculations shown in the tables are indicative of degree to which the benefits replace earnings over the period of the disability. On a nationwide basis, for a worker disabled at age 50, without dependents and with average earnings, the ratio of combined benefits to earnings from disability to age 65 ranges from less than 50 percent in the least favorable States to a maximum of about 99 percent in the State with highest workmen's compensation benefits.

In 19 States the replacement ratio of the combined benefits exceeds 66⅔ percent of assumed earnings at a time of disablement.

For a worker disabled at age 50, without dependents and with low earnings (25 percent less than average), the replacement ratio ranges from less than 60 percent to about 104 percent. In five States and the District of Columbia the ratios would exceed 100 percent. In 18 States, the replacement ratio would be less than 66⅔ percent. Conversely, for such a worker with wages 25 percent higher than average the total benefits under both programs payable between the date of disability and age 65, the ratio ranges from less than 40 percent to about 94 percent of expected earnings. In 25 States total benefits would amount to less than one-half expected earnings. In six States and the District of Columbia benefits would replace more than two-thirds of earnings.

For a worker disabled at age 40, with a wife and child aged 8, benefits under both programs would replace a larger proportion of earnings. In the case of a worker with average earnings, the replacement would range from about 51 percent to about 113 percent of earnings.

Worker disabled at age 50; no dependents; low earnings;[1] no increase in earnings or benefits levels

States	Total workmen's compensation to age 65	Total social security to age 65	Total combined benefits to age 65	Earnings to 65 at average at time of disablement	Percent replacement
Alabama	$13,200	$17,460	$30,660	$47,061	65.1
Alaska	41,067	22,860	63,927	87,968	72.7
Arizona	38,048	19,980	58,028	58,539	99.1
Arkansas	12,500	16,020	28,520	39,936	71.4
California	39,978	21,420	61,398	65,653	93.5
Colorado	31,395	19,440	50,835	56,503	90.0
Connecticut[2]	36,504	20,520	57,024	60,840	93.7
Delaware	39,000	21,060	60,060	63,726	94.2
District of Columbia	38,376	19,800	58,176	57,564	101.1
Florida	29,749	18,000	47,749	49,577	96.3
Georgia	10,000	17,280	27,280	45,833	59.5
Hawaii	32,963	18,000	50,963	49,452	103.1
Idaho	15,760	18,180	33,940	50,443	67.3
Illinois	39,780	21,060	60,840	63,500	95.8
Indiana	15,000	20,160	35,160	60,005	58.6
Iowa	18,500	18,720	37,220	52,580	70.8
Kansas	15,770	18,900	34,670	53,446	64.9
Kentucky	15,300	18,180	33,480	50,606	66.2
Louisiana	14,000	18,360	32,360	51,496	62.8
Maine	19,500	17,460	36,960	46,831	78.9
Maryland	30,000	18,720	48,720	53,056	91.8
Massachusetts	36,348	19,080	55,428	54,538	101.6
Michigan	25,740	21,780	47,520	67,033	70.9
Minnesota	25,623	19,440	45,063	56,215	80.2
Mississippi	12,500	16,020	28,520	40,599	70.2
Missouri	25,950	19,440	45,390	56,051	81.0
Montana	14,500	18,540	33,040	52,010	63.5
Nebraska	24,300	18,360	42,660	51,355	83.1
Nevada	29,250	21,600	50,850	65,941	77.1
New Hampshire	14,019	17,640	31,659	48,103	65.8
New Jersey	20,250	20,880	41,130	62,774	65.5
New Mexico	19,000	18,900	37,900	53,820	70.4
New York	42,182	20,880	63,062	63,281	99.7
North Carolina	10,000	16,560	26,560	43,111	61.6
North Dakota	32,760	17,820	50,580	48,649	104.0
Ohio	38,220	20,700	58,920	62,517	94.2
Oklahoma	15,000	18,540	33,540	52,096	64.4
Oregon	22,503	19,440	41,943	56,386	74.4
Pennsylvania	37,050	19,260	56,310	55,676	101.1
Rhode Island	29,632	18,000	47,632	49,382	96.5
South Carolina	10,000	16,380	26,380	41,933	62.9
South Dakota	12,000	18,180	30,180	50,708	59.5
Tennessee	12,500	17,460	29,960	47,151	63.5
Texas	14,035	18,540	32,755	52,510	62.4
Utah	26,302	18,900	45,202	53,867	83.9
Vermont	11,880	17,820	29,700	48,337	61.4
Virginia	14,000	17,640	31,640	47,603	66.5
Washington	29,702	20,520	50,222	61,682	81.4
West Virginia	29,640	19,440	49,080	56,488	86.9
Wisconsin	40,716	19,800	60,516	58,165	104.0
Wyoming	12,000	18,540	30,540	51,917	58.8

[1] The amount shown as "average earnings" is the average weekly wage in the State in employment covered by unemployment insurance during the 12-month period ending Sept. 30, 1962: High earnings means earnings 25 percent higher than the average for the State; low earnings means earnings 25 percent lower than the average for the State.

[2] State's average weekly production wage was used to compute maximum payments under workmen's compensation.

Worker disabled at age 50; no dependents; high earnings;[1] no increase in earnings or benefit levels

States	Total workmen's compensation to age 65	Total social security to age 65	Total combined benefits to age 65	Earnings to 65 at average at time of disablement	Percent replacement
Alabama	$13,200	$22,860	$36,060	$78,819.00	45.8
Alaska	41,067	22,860	63,927	146,608.80	43.6
Arizona	63,422	22,860	86,282	97,570.20	88.4
Arkansas	12,500	21,600	34,100	66,557.40	51.2
California	40,950	22,860	63,810	109,418.40	58.3
Colorado	31,395	22,860	54,255	94,169.40	57.6
Connecticut [2]	40,560	22,860	63,420	101,400.00	62.5
Delaware	39,000	22,860	61,860	106,204.80	58.2
District of Columbia	54,600	22,860	77,460	95,940.00	80.7
Florida	32,760	22,860	55,620	82,633.20	67.3
Georgia	10,000	22,860	32,680	76,385.40	42.8
Hawaii	54,935	22,860	77,795	82,414.80	94.4
Idaho	15,760	22,860	38,620	84,076.20	45.9
Illinois	39,780	22,860	62,640	105,830.40	59.2
Indiana	15,000	22,860	37,860	100,003.80	37.9
Iowa	18,500	22,860	41,360	87,633.00	47.2
Kansas	15,770	22,860	38,630	89,076.00	43.4
Kentucky	15,300	22,860	38,160	84,341.40	45.2
Louisiana	14,000	22,860	36,860	85,823.40	42.9
Maine	19,500	22,860	42,360	78,046.80	54.3
Maryland	30,000	22,860	52,860	88,420.80	59.8
Massachusetts	39,000	22,860	61,860	90,893.40	68.1
Michigan	25,740	22,860	48,600	111,719.40	43.5
Minnesota	23,955	22,860	46,815	93,685.80	50.0
Mississippi	12,500	21,960	34,460	67,665.00	50.9
Missouri	25,950	22,860	48,810	93,412.80	52.3
Montana	14,500	22,860	37,360	86,689.20	43.1
Nebraska	24,300	22,860	47,160	85,597.20	55.1
Nevada	29,250	22,860	52,110	109,902.00	47.4
New Hampshire	14,322	22,860	37,182	80,176.20	46.4
New Jersey	20,250	22,860	43,110	104,621.40	41.2
New Mexico	19,000	22,860	41,860	89,700.00	46.7
New York	42,900	22,860	65,760	105,468.80	62.4
North Carolina	10,000	22,860	32,860	71,845.80	45.7
North Dakota	32,760	22,860	55,620	81,081.00	68.6
Ohio	38,220	22,860	61,080	104,192.40	58.6
Oklahoma	15,000	22,860	37,860	86,821.80	43.6
Oregon	22,503	22,860	45,390	93,974.40	48.3
Pennsylvania	37,050	22,860	59,910	92,788.80	64.6
Rhode Island	31,200	22,860	54,060	82,297.80	65.7
South Carolina	10,000	22,320	32,320	69,888.00	46.2
South Dakota	12,000	22,860	34,860	34,518.00	41.7
Tennessee	12,500	22,860	35,360	78,585.00	45.0
Texas	14,035	22,860	36,895	87,516.00	42.2
Utah	30,420	22,860	53,280	89,778.00	59.3
Vermont	11,880	22,860	34,740	80,558.40	43.1
Virginia	14,000	22,860	36,860	79,333.80	46.5
Washington	29,702	22,860	52,562	102,804.00	51.1
West Virginia	29,640	22,860	52,500	94,146.00	55.8
Wisconsin	46,800	22,860	69,660	96,946.20	71.9
Wyoming	12,000	22,860	34,860	86,533.20	40.3

[1] The amount shown as "average earnings" is the average weekly wage in the State in employment covered by unemployment insurance during the 12-month period ending Sept. 30, 1962. High earnings means earnings 25 percent higher than the average for the State; low earnings means earnings 25 percent lower than the average for the State.

[2] State's average weekly production wage was used to compute maximum payments under workmen's compensation.

Worker disabled at age 40; wife and child age 8; average earnings; [1] *no increase in earnings or benefit levels*

States	Total workmen's compensation to age 65	Total social security to age 65	Total combined benefits to age 65	Earnings to 65 at average at time of disablement	Percent replacement
Alabama	$13,200	$48,720	$61,920	$104,624	59.2
Alaska	68,445	53,340	121,785	195,481	62.3
Arizona	84,565	53,340	137,905	130,091	106.0
Arkansas	12,500	44,100	56,600	88,733	63.8
California	68,250	53,340	121,590	145,886	83.3
Colorado	52,325	53,340	105,665	125,554	84.2
Connecticut	[2] 67,600	53,340	120,940	135,200	89.5
Delaware	65,000	53,340	118,340	141,609	83.6
District of Columbia	85,267	53,340	138,607	127,920	108.4
Florida	54,600	50,400	105,000	110,175	95.3
Georgia	10,000	47,880	57,880	101,842	56.8
Hawaii	73,255	50,400	123,655	109,889	112.5
Idaho	28,780	50,820	79,600	112,099	71.0
Illinois	68,016	53,340	121,356	141,102	86.0
Indiana	15,000	53,340	68,340	133,341	51.3
Iowa	18,200	52,080	70,580	116,834	60.4
Kansas	15,770	52,920	68,690	118,768	57.8
Kentucky	15,300	50,820	66,120	112,450	58.8
Louisiana	14,000	48,300	62,300	104,065	59.9
Maine	19,500	48,300	67,800	104,065	65.2
Maryland	30,000	52,500	82,500	117,897	70.0
Massachusetts	76,920	53,340	129,260	121,186	106.7
Michigan	48,464	53,340	101,804	148,954	68.3
Minnesota	30,223	53,340	83,563	124,917	66.9
Mississippi	12,500	44,520	57,020	90,220	63.2
Missouri	40,250	53,340	93,590	124,553	75.1
Montana	18,000	52,080	70,080	115,583	60.6
Nebraska	38,600	51,660	90,260	114,127	79.1
Nevada	64,500	53,340	117,840	146,536	80.4
New Hampshire	14,322	49,140	63,462	106,899	59.4
New Jersey	20,250	53,340	73,590	139,490	52.8
New Mexico	19,000	52,920	71,920	119,600	60.1
New York	71,500	53,340	124,840	140,621	88.8
North Carolina	10,000	45,780	55,780	95,797	58.2
North Dakota	56,160	49,560	105,720	108,108	97.8
Ohio	63,700	53,340	117,040	138,918	84.3
Oklahoma	15,000	52,080	67,080	115,765	57.9
Oregon	49,540	53,340	102,880	125,294	82.1
Pennsylvania	61,750	53,340	115,090	123,721	93.0
Rhode Island	52,000	49,980	101,980	109,783	92.9
South Carolina	10,000	45,360	55,360	93,184	59.4
South Dakota	12,000	50,820	62,820	112,684	55.7
Tennessee	12,500	48,720	61,220	104,780	58.4
Texas	14,035	52,080	66,115	116,688	56.7
Utah	55,705	53,340	109,045	119,704	91.1
Vermont	11,880	49,560	61,440	107,406	57.2
Virginia	14,000	49,140	63,140	105,781	59.7
Washington	60,960	53,340	114,300	137,072	83.4
West Virginia	49,400	53,340	102,740	125,528	81.4
Wisconsin	78,000	53,340	131,340	129,259	101.6
Wyoming	19,000	48,720	67,720	115,375	58.7

[1] The amount shown as "average earnings" is the average weekly wage in the State employment covered by unemployment insurance during the 12-month period ending Sept. 30, 1962. High earnings means earnings 25 percent higher than the average for the State; low earnings means earnings 25 percent lower than the average for the State.

[2] State's average weekly production wage was used to compute maximum payments under workmen's compensation.

Worker disabled at age 50; no dependents; average earnings;[1] no increase in earnings or benefit levels

States	Total workmen's compensation to age 65 (1)	Total social security to age 65 (2)	Total combined benefits to age 65 (3)	Earnings to 65 at average at time of disablement (4)	Percent replacement (5)
Alabama	$13,200	$20,880.00	$34,080.00	$62,774.00	54.3
Alaska	41,067	22,860.00	63,927.00	117,289.00	54.5
Arizona	50,789	22,860.00	73,599.00	78,055.00	94.3
Arkansas	12,500	18,915.00	31,415.00	53,242.80	59.0
California	40,950	22,860.00	63,810.00	87,731.60	72.9
Colorado	31,395	22,860.00	54,255.00	75,332.00	72.0
Connecticut	[2] 40,560	22,860.00	63,420.00	81,120.00	78.2
Delaware	39,000	22,860.00	61,860.00	84,966.00	72.8
District of Columbia	51,160	22,860.00	74,020.00	76,752.00	96.4
Florida	32,760	21,613.50	54,373.50	66,106.00	82.3
Georgia	10,000	20,520.00	30,520.00	61,105.00	49.9
Hawaii	43,983	21,600.00	65,583.00	65,933.00	99.4
Idaho	21,840	21,780.00	43,620.00	67,259.00	64.9
Illinois	39,780	22,860.00	62,640.00	84,661.20	74.0
Indiana	15,000	22,860.00	37,860.00	80,006.00	47.3
Iowa	18,500	22,320.00	40,820.00	70,106.00	58.2
Kansas	15,770	22,680.00	38,450.00	71,261.00	54.0
Kentucky	15,800	21,793.20	37,093.20	67,470.00	55.0
Louisiana	14,000	22,159.80	36,159.80	62,439.00	57.9
Maine	19,600	20,700.00	40,200.00	62,439.00	64.4
Maryland	30,000	22,500.00	52,500.00	70,788.00	74.2
Massachusetts	39,000	22,860.00	61,860.00	72,711.60	85.1
Michigan	25,740	22,860.00	48,600.00	89,372.40	54.4
Minnesota	23,955	22,860.00	46,815.00	74,960.00	62.5
Mississippi	12,500	19,080.00	31,580.00	54,182.00	58.3
Missouri	25,950	22,860.00	48,810.00	74,731.80	65.3
Montana	14,500	22,320.00	36,820.00	69,350.00	53.1
Nebraska	24,300	22,140.00	46,440.00	68,476.00	67.8
Nevada	29,250	22,860.00	52,110.00	87,922.00	59.3
New Hampshire	14,322	21,060.00	35,382.00	64,189.00	55.2
New Jersey	20,250	22,860.00	43,110.00	83,694.00	51.5
New Mexico	19,000	22,680.00	41,680.00	71,760.00	58.1
New York	42,900	22,860.00	65,760.00	84,372.60	77.9
North Carolina	10,000	19,620.00	29,620.00	57,478.00	51.5
North Dakota	32,760	21,240.00	54,000.00	64,865.00	83.2
Ohio	38,220	22,860.00	61,080.00	83,350.80	73.3
Oklahoma	15,000	22,320.00	37,320.00	69,459.00	53.7
Oregon	22,503	22,860.00	45,363.00	75,176.40	60.3
Pennsylvania	37,050	22,860.00	59,910.00	74,232.60	80.7
Rhode Island	31,200	21,600.00	52,800.00	65,840.00	80.2
South Carolina	10,000	19,440.00	29,440.00	55,910.00	52.7
South Dakota	12,000	21,780.00	33,780.00	67,610.00	50.0
Tennessee	12,500	20,896.20	33,396.20	62,868.00	53.1
Texas	14,035	22,339.20	36,374.20	70,012.80	52.0
Utah	30,420	22,860.00	53,280.00	71,822.00	74.2
Vermont	11,880	21,240.00	33,120.00	64,444.00	51.4
Virginia	14,000	21,075.60	35,075.60	63,468.60	55.3
Washington	29,702	22,860.00	52,562.00	82,248.00	63.9
West Virginia	29,640	22,860.00	52,500.00	75,317.00	69.7
Wisconsin	46,800	22,860.00	69,660.00	77,555.40	89.8
Wyoming	12,000	22,140.00	34,140.00	69,225.00	49.3

[1] The amount shown as "average earnings"; the average weekly wage in the State in employment is covered by unemployment insurance during the 12-month period ending Sept. 30, 1962. High earnings means earnings 25 percent higher than the average for the State; low earnings means earnings 25 percent lower than the average for the State.

[2] State's average weekly production wage was used to compute maximum payments under workmen's compensation.

Worker disabled at age 40; wife; and child age 8; high earnings;[1] no increase in earnings or benefit levels

States	Total workmen's compensation to age 65	Total social security to age 65	Total combined benefits to age 65	Earnings to 65 at average at time of disablement	Percent replacement
Alabama	$18,200	$53,340	$66,540	$130,780	50.9
Alaska	68,445	53,340	121,785	244,848	49.8
Arizona	105,703	53,340	159,043	162,617	97.8
Arkansas	12,500	50,400	62,900	110,929	56.7
California	68,250	53,340	121,590	182,364	66.7
Colorado	52,325	53,340	105,665	156,949	67.3
Connecticut	[2] 67,600	53,340	120,940	169,000	71.6
Delaware	65,000	53,340	118,340	177,008	66.9
District of Columbia	91,000	53,340	144,340	159,900	90.3
Florida	54,600	53,340	107,940	137,722	78.4
Georgia	10,000	53,340	63,340	127,309	49.8
Hawaii	91,559	53,340	144,899	137,358	105.5
Idaho	28,780	53,340	82,120	140,127	58.6
Illinois	68,016	53,340	121,356	176,384	68.8
Indiana	15,000	53,340	83,340	166,673	41.0
Iowa	18,500	53,340	71,840	146,055	49.2
Kansas	15,770	53,340	69,110	148,460	46.6
Kentucky	15,300	53,340	68,640	140,569	48.8
Louisiana	14,000	53,340	67,340	143,099	47.1
Maine	19,500	53,340	72,840	130,078	56.0
Maryland	30,000	53,340	83,340	147,368	56.6
Massachusetts	75,920	53,340	129,260	151,489	85.3
Michigan	48,464	53,340	101,804	186,199	54.7
Minnesota	30,223	53,340	83,563	156,143	53.5
Mississippi	12,500	51,240	63,740	112,775	56.5
Missouri	40,250	53,340	93,590	155,688	60.1
Montana	18,000	53,340	71,340	144,482	49.4
Nebraska	38,600	53,340	91,940	142,662	64.4
Nevada	64,500	53,340	117,840	183,170	64.3
New Hampshire	14,322	53,340	67,662	133,627	50.6
New Jersey	20,250	53,340	73,590	174,369	42.2
New Mexico	19,000	53,340	72,340	149,500	48.4
New York	71,500	53,340	124,840	175,773	71.0
North Carolina	10,000	53,340	63,340	119,743	52.9
North Dakota	56,156	53,340	109,500	135,135	81.0
Ohio	63,700	53,340	117,040	173,654	67.4
Oklahoma	15,000	53,340	68,340	144,703	47.2
Oregon	49,540	53,340	102,880	156,624	65.7
Pennsylvania	61,750	53,340	115,090	154,648	74.4
Rhode Island	52,000	53,340	105,340	137,163	76.8
South Carolina	10,000	52,080	62,080	116,480	53.3
South Dakota	12,000	53,340	65,340	140,855	46.4
Tennessee	12,500	53,340	65,840	130,975	50.3
Texas	14,035	53,340	67,375	145,880	46.2
Utah	55,705	53,340	109,045	149,630	72.9
Vermont	11,880	53,340	65,220	134,264	48.6
Virginia	14,000	53,340	67,340	132,223	50.9
Washington	60,960	53,340	114,300	171,340	66.7
West Virginia	49,400	53,340	102,740	156,910	65.5
Wisconsin	78,000	53,340	131,340	161,471	81.3
Wyoming	19,000	53,340	72,340	144,222	50.2

[1] The amount shown as "average earnings" is the average weekly wage in the State in employment covered by unemployment insurance during the 12-month period ending Sept. 30, 1962: High earnings means earnings 25 percent higher than the average for the State; low earnings means earnings 25 percent lower than the average for the State.

[2] State's average weekly production wage was used to compute maximum payments under workmen's compensation.

Worker disabled at age 40; wife and child age 8; low earnings; no increase in earnings[1] or benefit levels

States	Total workmen's compensation to age 65	Total social security to age 65	Total combined benefits to age 65	Earnings to 65 at average at time of disablement	Percent replacement
Alabama	$18,200	$40,740	$58,940	$78,468	68.7
Alaska	68,445	53,340	121,785	146,614	83.1
Arizona	63,414	46,620	110,034	97,565	112.8
Arkansas	12,500	37,380	49,880	66,560	74.9
California	66,238	49,980	116,218	109,421	106.2
Colorado	52,525	45,360	97,685	94,172	103.7
Connecticut	[2] 60,840	47,880	108,720	101,400	107.2
Delaware	69,000	49,140	118,140	106,210	107.5
District of Columbia	65,960	46,200	110,160	95,040	114.8
Florida	49,582	42,000	91,582	82,623	110.8
Georgia	10,000	40,320	50,320	76,388	65.9
Hawaii	54,938	42,000	96,938	82,420	117.6
Idaho	28,780	42,420	71,200	84,071	84.7
Illinois	68,016	49,140	117,156	106,838	110.7
Indiana	15,000	47,040	62,040	100,009	62.0
Iowa	18,500	43,680	62,180	87,633	71.0
Kansas	15,770	44,100	59,870	89,076	67.2
Kentucky	13,300	42,420	57,720	84,244	68.4
Louisiana	14,000	42,840	56,840	85,826	66.2
Maine	19,500	40,740	60,240	78,052	77.2
Maryland	30,000	43,680	73,680	88,426	83.3
Massachusetts	71,513	44,520	116,033	90,896	127.7
Michigan	48,464	50,820	99,284	111,722	88.9
Minnesota	33,647	45,360	79,007	93,691	84.3
Mississippi	12,500	37,380	49,880	67,665	73.7
Missouri	40,250	45,360	85,610	93,418	91.6
Montana	18,000	43,260	61,260	86,684	70.7
Nebraska	38,600	42,840	81,440	85,597	95.1
Nevada	64,500	50,400	114,900	109,902	104.5
New Hampshire	14,019	41,160	55,179	80,171	68.8
New Jersey	20,250	48,720	68,970	104,624	65.9
New Mexico	19,000	44,100	63,100	89,700	70.3
New York	70,304	48,720	119,024	105,469	112.9
North Carolina	10,000	38,640	48,640	71,851	67.7
North Dakota	56,160	41,580	97,740	81,081	120.5
Ohio	63,700	48,300	112,000	104,195	107.5
Oklahoma	15,000	43,260	58,260	86,827	67.1
Oregon	49,540	45,360	94,900	93,977	101.0
Pennsylvania	61,750	44,940	106,690	92,794	115.0
Rhode Island	49,387	42,000	91,387	82,303	111.0
South Carolina	10,000	38,220	48,220	69,888	69.0
South Dakota	12,000	42,420	54,420	84,513	64.4
Tennessee	12,500	40,740	53,240	78,585	67.7
Texas	14,035	43,260	57,295	87,516	65.5
Utah	47,468	44,100	91,568	89,778	102.0
Vermont	11,880	41,580	53,460	80,561	66.4
Virginia	14,000	41,160	55,160	79,339	69.5
Washington	60,960	47,880	108,840	102,700	106.0
West Virginia	49,400	45,360	94,760	94,146	100.7
Wisconsin	67,860	46,200	114,060	96,941	117.7
Wyoming	19,000	43,260	62,260	86,528	72.0

[1] The amount shown as "average earnings" is the average weekly wage in the State in employment covered by unemployment insurance during the 12-month period ending Sept. 30, 1962. High earnings means earnings 25 percent higher than the average for the State; low earnings means earnings 25 percent lower than the average for the State.

[2] State's average weekly production wage was used to compute maximum payments under workmen's compensation.

Estimates of the Proportion of Workers Concurrently Entitled to Social Security Disability Benefits and Workmen's Compensation

On May 17, questions were raised concerning the number of workers who are entitled concurrently to workmen's compensation and social security disability benefits, and as to what proportion would be concurrently entitled to benefits under both programs after enactment of H.R. 6675. Although some data are available on the basis of which reasonable answers can be given to these questions, it is recognized that more precise information would be helpful. It is for this reason that the Committee on Ways and Means of the House of Representatives requested the Social Security Administration, in cooperation with the State workmen's compensation agencies, to conduct a study of the extent and significance of overlapping benefits between workmen's compensation and the social security disability program. The evidence that is available indicates that among workers entitled to social security disability benefits under present law, no more than between 1.5 and 2.7 percent are receiving workmen's compensation. About 900,000 workers were receiving social security disability benefits at the end of 1964.

Among the estimated 70,000 workers who would become entitled to social security disability benefits in the first year following enactment of the amendments proposed in H.R. 6675, some would also be receiving workmen's compensation; however, it seems probable that the proportion of those concurrently entitled under both programs would not increase significantly.

The number of persons receiving workmen's compensation in any one week or month is not known. There are, however, figures on the number of workmen's compensation awards of disability benefits and these awards are some 900,000 per year. The proportion of those awarded workmen's compensation periodic benefits who are receiving social security disability benefits or who would receive such benefits upon enactment of H.R. 6675 is estimated at perhaps 1 percent of those awarded workmen's compensation. Following is a summary of evidence leading to these conclusions.

Concurrent Eligibility Among Workers Receiving Social Security Disability Benefits Under Present Law

Experience under repealed offset provision

This offset provision was in effect July 1957 to July 1958. During this period, benefits were withheld or reduced in about 2.7 percent of the cases of those awarded social security disability benefits.

Beneficiary survey, 1960

Information on the extent to which persons were entitled to the two benefits was also collected during a survey of persons found disabled under the social security provisions conducted late in 1960 by the Social Security Administration. The sample was drawn on a random basis from workers who had been found disabled under the social security program and who were living in the eight largest metropolitan statistical areas as defined by the Bureau of the Census: New York, Chicago, Los Angeles, Philadelphia, Detroit, San Francisco, Boston, and Pittsburgh. These are highly industrialized areas, some of them in States that have comprehensive workmen's compensation laws. Of the disabled persons included in this survey, less than 1.7 percent were getting workmen's compensation.

Survey of delayed filing, April 1963

This was a sample survey of new applicants for disability benefits conducted in April 1963 to determine the causes of delays in filing applications. Among those interviewed whose applications were allowed, some 4.5 percent had received workmen's compensation at some time between onset of disability and the time application was filed, and 2.5 percent were receiving workmen's compensation at the time applications were filed. (Mr. Dorsett refers to an October 1964 social security bulletin article estimate of 75,000 long-term disabled persons receiving workmen's compensation, and suggests that these disabled persons would also be entitled to benefits under H.R. 6675. However, he fails to note that some of these persons would not meet the work requirements for social security benefits and that persons were included in the estimate who would have been able to do some work but not their regular work and would not then be entitled to social security benefits.)

CONCURRENT ENTITLEMENT TO SOCIAL SECURITY BENEFITS AMONG WORKERS AWARDED WORKMEN'S COMPENSATION

Information concerning losses under policies issued by carriers and competitive State funds in 41 States and the District of Columbia, reported to the National Council on Compensation Insurance for ratemaking purposes, shows about 650,000 compensation awards in each of the policy years 1955–61 of which about 500 to 600 involved permanent and total disability. Permanent partial disabilities of 75 percent or more of total are classified as permanent and total disabilities in these reports so that some of these might not be allowed social security benefits. (See app. A, attached.)

CONCURRENT ELIGIBILITY UNDER THE AMENDMENTS TO H.R. 6675

A study (published in the proceedings of the Casualty Actuarial Society, vol. 42) of a number of the characteristics of workmen's compensation awards based on reports from carriers to the National Council on Compensation Insurance and certain independent rating bureaus contains information about the duration of disabilities compensable under workmen's compensation as temporary total disabilities. According to this study out of 68,044 compensable disabilities, 842 (a little over 1 percent) lasted more than 175 days (6 months). (See app. B.) Assuming that the same ratio applies in cases currently awarded temporary total disability (rated at least 75-percent disabled under workmen's compensation) this would mean perhaps no more than 10,000 annual awards in the United States for temporary total disability lasting at least 6 months (or 1¼ percent of all workmen's compensation awards based on temporary total disability). Some of these 10,000 would not be insured for disability. Moreover, since workmen's compensation payments would be made under these awards for no more than about 1 year on the average, many of the disabled workers who are insured would be receiving benefits under both programs for only part of the year, with the result that the number receiving benefits under both programs for any one month would be further reduced.

It seems clear from this information that the increase in the number of persons concurrently receiving benefits under both programs resulting from the enactment of H.R. 6675 may be expected to be quite small, increasing by about 5,000 at most from the present level of less than 80,000 (based on a maximum estimate of 2.7 percent of 900,000 workers receiving disability benefits).

Senator WILLIAMS. I am just told this what they submitted but in reading this what they have submitted is based on the bill as it is presently in effect under existing law. They do not say here in this report, and the figures on how it would be affected under this present bill if and when it is enacted, so when those figures are submitted, I still want them submitted here at this point.

Mr. DORSETT. Fine.

Senator LONG. Senator Douglas.

Senator DOUGLAS. Mr. Dorsett, I regret I was not here when you presented your testimony but I read it through twice and I am uncertain what it is that you prefer.

Do you want to have all payments for cases of permanent total disability under workmen's compensation eliminated from the act or do you want to have the workmen's compensation payments offset and deducted against social security disability?

Mr. DORSETT. Under the original law, Senator Douglas, as you will recall, there was an offset. We believe that you should return to that fundamentally sound principle. To me it seems that the result that I am about to describe is completely out of good conscience. If as an employee I am injured, under the New York law I get workmen's compensation; it is completely unsound in a social security law to add to that and pay me more than I was getting while I was at work. To me it is just unbelievable. Now, we would like to see the offset provision restored.

Senator DOUGLAS. But you also say that you would strike the whole provision and eliminate workmen's compensation from total disability cases. Now, which do you advocate? Mr. Kalmykow, you have lived with the question.

Mr. KALMYKOW. Senator Douglas, some have requested the thought of studying the subject a little further before acting on it. If that is the preference of this committee or if this committee feels that is a desirable thing to give study to this subject, certainly we don't think that the area of duplication should be increased pending that study.

We would prefer if we could maintain the status quo while the study was being made.

Senator DOUGLAS. You mean the existing provisions so that there would be double payment?

Mr. KALMYKOW. This bill would greatly broaden the area of duplication, so we request that the area of duplication not be broadened pending any study that might be made.

Senator DOUGLAS. How does this bill broaden the area beyond the 1960 provision?

Mr. KALMYKOW. It provides for compensation for temporary total disability as well as permanent. That is a very drastic change in the concept of coverage under the Social Security Act for disability payments. Up to this time only cases of permanent and total disability in effect have been covered although that concept has been expanded over the recent years.

However, the principle still remains. This would depart from that principle and provide disability benefits for persons who may return to work, 2 or 3 weeks, following a 6-month period of disability.

Senator DOUGLAS. Are you speaking also of medical benefits?

Mr. KALMYKOW. No, not medical benefits, disability benefits. It has nothing to do with medical benefits. That has an exception built into it.

Senator ANDERSON. Could I ask him one more question?

Senator DOUGLAS. Yes, by all means.

Senator ANDERSON. When a man is injured does he begin drawing disability after a reasonable number of days?

Mr. KALMYKOW. Under workmen's compensation the waiting period depends; it varies from State to State. The range is somewhere between 3 and 7 days.

Senator DOUGLAS. So after 7 days he begins drawing compensation?

Mr. KALMYKOW. That is right.

Senator DOUGLAS. If he draws that compensation for 6 months does it stop then?

Mr. KALMYKOW. No, it keeps right on going.

Senator DOUGLAS. So what is your distinction between this temporary and permanent disability? Doesn't he still draw money whether it is temporary or permanent at the end of 6 months.

Mr. KALMYKOW. That is correct. I believe——

Senator DOUGLAS. Why does that duplicate the payments?

Mr. KALMYKOW. The social security disability payments begin, under this bill, at the end of the fifth month. In other words, at the end of the fifth month he would start getting social security payments.

Senator DOUGLAS. There is 1 month overlap.

Mr. KALMYKOW. No, we go on forever; from that month on there would be overlap during the full term of the disability, it may last a life.

Senator DOUGLAS. It has been some years since I looked at the schedules for compensation under the various State workmen's compensation laws, but when I last looked at them I did not think that they gave adequate protection for the loss of earnings or for the medical costs involved.

Now, you seem to think that they do.

Mr. DORSETT. Improvement could be had in a great many jurisdictions. I suppose the average, and you correct me if I am wrong, is about 66⅔ percent of their average weekly wage.

Senator DOUGLAS. For how long?

Mr. DORSETT. In most States as long as you are totally—as you are totally disabled, even for life.

Senator ANDERSON. You don't mean to say you think the average over the country is 66⅔ percent?

Mr. DORSETT. No, I was going to add in dollars.

Senator ANDERSON. Only four States, isn't that right?

Mr. DORSETT. Beg pardon?

Senator ANDERSON. Only four States go that high.

Mr. DORSETT. I would think it is considerably more than four.

Mr. KALMYKOW. It is considerably more than that. There is a weekly maximum which averages over $50 a week at the present time.

Senator DOUGLAS. Isn't $50 a week now only about 50 percent of average weekly earnings, or slightly less than 50 percent of average weekly earnings?

Mr. KALMYKOW. You have in mind without any deduction for income tax or social security. If you take that into account it comes pretty close to that.

Senator LONG. Pretty close to that.

Mr. KALMYKOW. An average of 65 percent on a take-home pay basis.

Senator DOUGLAS. Mr. Chairman, I suggest we ask the Bureau of Labor Statistics to prepare a tabulation for us of the comparative benefit schedules of the various States on permanent, permanent total, permanent partial, temporary total, and temporary partial disability caused by industrial accidents, together with a rough estimate of the number of cases in each State.

(The information referred to follows:)

TYPES OF BENEFITS

Under the workmen's compensation laws, various types of benefits are provided for the injured worker, or, in case of his death, for his family. These include medical services, benefit payments to the worker during period of disablement, and for permanent disabilities, death benefits to the worker's family, and under all but one law, burial allowances.

Benefits that injured workers receive vary according to the type of injury—whether it is a partial or a total injury, and whether it develops into a permanent disability or is only temporary.

Some States also provide additional special benefits, such as payment for constant attendants, if needed, or prostheses as needed, or extra benefits in case of disfigurement. Some provide extra benefits for minors injured while illegally employed. In addition, benefits for maintenance and other rehabilitation services for injured workers are provided under almost half the workmen's conpensation laws.

MEDICAL BENEFITS [1]

When a worker is injured, he first of all needs medical aid, and perhaps hospitalization. Under all compensation acts, medical aid is required to be furnished to injured employees. In the early legislation, the provision for medical aid was narrowly restricted as to the monetary amount, the period of treatment, or both. Later such absolute restrictions were changed in many cases, either by providing for unlimited benefits or by authorizing benefits in addition to the initial maximum, upon the approval of the administrative authority.

As shown in table 6, 39 States, the District of Columbia, Puerto Rico, and the Federal employees' and longshoremen's acts give full medical aid. Twenty-four of these forty-three laws specifically provide that medical aid must be furnished without limit as to time or amount. Under the Arizona law, full medical aid is authorized through a combination of the medical care and rehabilitation provisions of the law. In 18 of the 43, medical benefits are considered to be unlimited because the administrative agency can extend such services indefinitely. It should be pointed out, however, that as shown in the footnotes to table 6, several States still place arbitrary limitations upon medical aid for certain occupational diseases.

In the remaining 11 laws, period-of-time or cost limitations, or both, are set by law. Certain extensions are authorized by the State administrative agency in all but Alabama, Kansas, and Louisiana. In these three States, extensions are not permitted beyond the initial amount or period shown in table 6. In contrast to several laws that pay full medical benefits in cases of accidental injuries but only limited benefits in cases of occupational diseases, in Colorado the 6 months' limitation does not apply to occupational diseases, and in New Mexico additional unlimited monetary benefits may be authorized for occupational diseases.

TABLE 6.—*Medical benefits*

FULL BENEFITS

State	Law specifies full benefits	Law limits period or amount but authorizes administrative agency to extend without limit	State	Law specifies full benefits	Law limits period or amount but authorizes administrative agency to extend without limit
Alaska	No	Yes.	Nevada [1]	No	Yes.
Arizona [1]	(2)	(2).	New Hampshire	No	Yes. [3]
Arkansas [1]	No	Yes.	New Jersey	No	Yes.
California	Yes		New York	Yes	
Connecticut	Yes		North Carolina [1]	No	Yes. [3]
Delaware	Yes		North Dakota	Yes	
District of Columbia	Yes		Ohio	Yes [4]	
Florida	Yes		Oklahoma	No	Yes.
Hawaii	Yes		Oregon	Yes [4]	
Idaho	Yes		Pennsylvania	No	Yes. [3]
Illinois [1]	Yes		Puerto Rico	Yes	
Indiana	No	Yes.	Rhode Island	No	Yes.
Iowa	No	Yes.	South Carolina	No	Yes.
Kentucky	No	Yes.	Texas [1]	Yes	
Maine [1]	Yes		Utah [1]	No	Yes.
Maryland	Yes		Vermont [1]	No	Yes.
Massachusetts	Yes		Washington [1]	Yes	
Michigan	No	Yes.	Wisconsin	Yes	
Minnesota	Yes		Wyoming	No	Yes.
Mississippi	Yes		United States:		
Missouri	No	Yes.	Federal employees	Yes	
Nebraska	Yes		Longshoremen	Yes	

See footnotes at end of table.

[1] For further information on medical care and benefits, see "Medical Care Under Workmen's Compensation," Bulletin 244, U.S. Department of Labor, Bureau of Labor Standards, 1962.

TABLE 6.—*Medical benefits*—Continued

LIMITED BENEFITS

State	Initial limitation		Limitation on time or monetary benefits after extension by administrative agency
	Time	Money	
Alabama	2 years	$2,400	No additional benefits permitted.
Colorado	6 months [6]	2,500	$3,500.
Georgia	10 weeks	2,000	Unlimited time and $2,500.
Kansas		[1] 6,000	No additional benefits permitted.
Louisiana		2,500	Do.
Montana	36 months [7]	[7] [8] 2,500	(7).
New Mexico	5 years	[9] 3,000	$15,000.
South Dakota	20 weeks	1,700	$2,000.
Tennessee	1 year	1,800	$2,500.
Virginia	90 days		2 years.
West Virginia		[10] 2,400	$3,200.

[1] However, benefits are limited for occupational diseases in Arizona (to $1,000) and in Utah (to $1,925.01); and for silicosis or asbestosis in the following States: Arkansas, 180 days; Illinois, 6 months; Kansas, 120 days—may be extended up to 210 days in special cases; Maine, $1,000; Nevada, $50 per month; North Carolina $1,000 a year, 3 years; Texas, 91 days; Vermont, $1,000.

[2] Arizona: Full medical aid, in the judgment of the Arizona Industrial Commission, is authorized through a combination of the medical care and rehabilitation provisions of the law.

[3] Additional medical care may be ordered in New Hampshire if supported by findings of 3 physicians; in North Carolina if the care would lessen the period of disability; and in Pennsylvania if it would substantially restore the worker's earning power.

[4] The Ohio and Oregon laws set no initial amount or period; all medical benefits authorized by the administrative agency. In Ohio in silicosis cases, no medical benefits payable unless total disability or a change of occupation.

[5] Washington: Under certain conditions, medical benefits terminate.

[6] Colorado: The 6-month limitation applies to accidental injuries; there is no time limitation for occupational diseases. Benefits for silicosis, asbestosis, and anthracosis are payable only if the commissioner determines that medical treatment will materially improve the worker's condition.

[7] Montana: In cases of occupational diseases: (a) the 36 months does not apply; (b) the $2,500 and its extension applies if the disability is total; and (c) if an employee continues work while undergoing medical care, the monetary benefits are limited to $1,000.

[8] Montana: In cases of total disability where $2,500 is not sufficient, an additional monetary amount may be allowed for hospitalization.

[9] New Mexico: For occupational diseases, the initial amount is $700; addition funds, unlimited as to period or amount, may be authorized by court order.

[10] West Virginia: No medical benefits are payable in silicosis cases.

TEMPORARY TOTAL DISABILITY

The great majority of cases for which cash benefits are paid involve temporary total disability; that is, the employee is unable to work at all while he is recovering from the injury, but he is expected to recover fully. The disability ends with the recovery of the injured person and his return to work. Table 7, relating to benefits for such disability, shows the maximum percentage of wages used in computing benefits, and the maximum period for which benefits are paid. It shows also the minimum and maximum payments per week, as well as the total maximum amounts where these are expressly stated in the laws.

The amount of benefits in most of these laws is based on a percentage of the worker's wages, usually 60, 65, or 66⅔ percent. As to monetary amounts, these are increased in many States every legislative session. For instance, in 1963, 22 States raised benefits for temporary total disability.

As of September 1957, 12 laws provided for maximum payments of $50 or over (including dependents' allowances); by April 1960 this number had grown to 19; and by September 1964 to 26—the 2 Federal laws and the following jurisdictions:

Alaska
Arizona
California
Connecticut
Delaware
District of Columbia
Hawaii
Idaho
Illinois
Iowa
Massachusetts
Michigan
Montana
Nevada
New York
North Dakota
Ohio
Oregon
Rhode Island
Utah
Vermont
Washington
Wisconsin
Wyoming

TABLE 7.—*Minimum and maximum benefits for temporary total disability*

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
Alabama	[1] 55-65	300 weeks	$15, or average wage if less.	$38	
Alaska	65	Duration of disability.	$25, or average wage if less.	$100	$20,000.
Arizona	65	433 weeks	$30 if worker is 21 years of age of over.	$150, plus $2.30 for total dependents.	
Arkansas	65	450 weeks	$7	$35	$12,500.
California	[2] 61⅔	240 weeks	$25	$70	
Colorado	66⅔	Duration of disability.	$10	$43.75 [3]	([3]).
Connecticut	60	do	$20	55 percent of State's "average production wage." [4]	
Delaware	66⅔	do	$25, or actual wage if less.	$50	
District of Columbia.	66⅔	do	$18, or average wage if less.	$70	$24,000.
Florida	60	350 weeks	$8, or actual wage if less.	$42	
Georgia	60	400 weeks	$12 or actual wage if less.	$37	$12,500.
Hawaii	66⅔	Duration of disability.	$18, or average wage if less.	$75	$25,000.
Idaho	[1] 55-60	400 weeks; [5] thereafter $15 per week ($18 if dependent wife) plus $4 to $15 for children, for duration of disability.	$15 ($18 if dependent wife) to $33. [1]	$32 to $52 [1] (see col. 3).	
Illinois	[1] 65-80	Duration of disability until equivalent of death benefit is paid, except in specific injury cases limited to 64 weeks.	$31.50 to $49 [1]	$51 to $81 [1]	$13,500 to $17,500. [1]
Indiana	60	500 weeks	$18	$42	$16,500.
Iowa	66⅔	300 weeks	$18, or actual wage if less.	$34 to $50 [1]	
Kansas	60	415 weeks	$7	$42	$17,430.
Kentucky	66⅔	425 weeks [5]	25 percent of 85 percent of the State's average weekly wage.	55 percent of 85 percent of the State's average weekly wage.	
Louisiana	65	300 weeks	$10, or actual wage if less.	$35	
Maine	66⅔	500 weeks	$18	$42	$21,000.
Maryland	66⅔	208 weeks	$18 or actual wage if less.	$48	
Massachusetts	66⅔	Duration of disability.	$20, or average wage if less, but not less than $10 if normal working hours are 15 or more.	$63, plus $6 for each total dependent. Aggregate shall not exceed the average weekly wage of the employee.	$16,000, plus dependents' allowances. [6]
Michigan	66⅔	500 weeks	$18 to $23 [1]	$33 to $57 [1]	([7]).
Minnesota	66⅔	350 weeks	$17.50	$45	
Mississippi	66⅔	450 weeks	$10	$35	$12,500.
Missouri	66⅔	400 weeks	$16, or actual wage if less.	$47.50	
Montana	[1] 50-66⅔	300 weeks	$25.50	$29 to $50 [1]	
Nebraska	66⅔	300 weeks; [5] thereafter 45 percent of wages, maximum $32.	$26, or actual wage if less, 1st 300 weeks; thereafter $22, or actual wage if less.	$40 (see col. 3)	
Nevada	[1] 65-90	433 weeks	No statutory minimum.	$45 to $62.31 [1]	
New Hampshire	66⅔	312 weeks; thereafter annual extensions in the discretion of the labor commissioner.	$15, or average wage if less.	$45	
New Jersey	([7])	300 weeks	$10	$45	

See footnotes at end of table.

TABLE 7.—*Minimum and maximum benefits for temporary total disability*—Con.

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
New Mexico	60	500 weeks	$24, or actual wage if less.	$38	$20,000.
New York	66⅔	Duration of disability.	$20, or actual wage if less.	$55	$6,500.
North Carolina	60	400 weeks [2]	$10	$37.50	$12,000. [2]
North Dakota	80	Duration of disability.	$15, plus $3 for each dependent child under 18, or those over 18 incapable of self-support.	$43 to $60 [1]	
Ohio	66⅔	do	$25, or actual wage if less.	$56 for the 1st 12 weeks; thereafter $49.	$10,750.
Oklahoma	66⅔	300 weeks; may be extended to 500 weeks.	$15, or actual wage if less.	$37.50	
Oregon	[1] 50–75	Duration of disability.	$30, or actual wage if less.	$32.31 to $66.92 [1]	
Pennsylvania	66⅔	do	$27.50, or 90 percent of actual wage if less, but in no event less than $20.	$47.50	
Puerto Rico	66⅔	312 weeks	$8	$35	
Rhode Island	60	Duration of disability. [10]	$17 if worker is receiving benefits under the State temporary disability insurance act. $22 if worker is not receiving benefits under the State temporary disability insurance act.	$ if worker is receiving benefits under the State temporary disability insurance act. $45 to $57 [1] if worker is not receiving benefits under the State temporary disability insurance act.	
South Carolina	60	500 weeks	$5	$35	$10,000.
South Dakota	55	312 weeks	$20, or average wage if less.	$38	$13,500.
Tennessee	65	300 weeks	$15, or average wage if less, but in no event less than $12.	$36	
Texas	60	401 weeks	$9	$35	
Utah	60	312 weeks	$25 to $39.25, [1] or actual wage if less.	$40 to $54.25 [1]	$11,204 to $15,126. [1]
Vermont	66⅔	330 weeks [3]	$20, plus $2.50 for each dependent child under 21, or average wage if less.	$39, plus $2.50 for each dependent child under 21.	
Virginia	60	500 weeks	$14	$39	$15,600.
Washington		Duration of disability.	Same as maximum.	$38.08 to $71.54 [1]	
West Virginia	66⅔	208 weeks	$22	$38	
Wisconsin	70	Duration of disability.	$8.75	$64	
Wyoming	66⅔	do	$30 to $46.15 [1]	$40.38 to $60 [1]	
United States: Federal employees.	[1] 66⅔–75	do	$41.54, or actual wage if less.	$121.15	
Longshoremen	66⅔	do	$18, or average wage if less.	$70	$24,000.

[1] According to number of dependents. In Idaho, Oregon, Washington, and Wyoming, according to marital status and number of dependents. In Illinois, according to number of dependent children under 16, or under 18 when not emancipated.

[2] The California law provides for 65 percent of 95 percent of actual earnings, or 61¾ percent.

[3] Colorado: If periodic disability benefits are payable to the worker under the Federal OASDI, the workmen's compensation weekly benefits shall be reduced (but not below zero) by an amount approximating ½ such Federal benefits for such week. If disability benefits are payable under an employer pension plan, the workmen's compensation benefits shall be reduced in an amount proportional to the employer's percentage of total contributions to the plan. Colorado does not limit total maximum for disability from accidental injury, except that if payable in lump sum, maximum is $13,650; in case of occupational diseases the maximum is $18,693.75.

Footnotes continued on following page.

Rhode Island is included on the above list, but the maximum of $57 is payable only if the worker is not receiving benefits under the State temporary disability insurance law; otherwise the maximum is $40. Ohio pays a maximum of $56 for the first 12 weeks, but drops to $49 thereafter.

Under 13 laws, the maximums range from $40 to under $50; while the remaining 15 still set maximums of under $40 a week.

Most of the laws limit the period during which temporary total benefits may be paid; this ranges from 208 to 500 weeks. There is a growing trend, however, toward paying benefits for the entire period of disability with no limitation on the amount, and the following 13 States as well as the Federal Employees' Act now contain such provisions:

Colorado (however, compensation for occupational diseases limited to $13,693.75)
Connecticut
Delaware
Idaho
Nebraska
New Hampshire (after the first 312 weeks, annual extensions may be authorized)
North Dakota
Oregon
Pennsylvania
Rhode Island
Washington
Wisconsin
Wyoming

Seven other laws, those of Alaska, the District of Columbia, Hawaii, Massachusetts, New York, Ohio, and the longshoremen's act specify payments of benefits for the entire period of disability, but set a maximum monetary limitation.

Injured persons who are compensated for temporary total disability may receive additional benefits for dependent children in 16 States.[2]

PERMANENT PARTIAL DISABILITY

A permanent partial disability means that a worker has a permanent injury, but is not completely disabled. He is usually able to work. If he cannot go back to his old job, he can often do, or be trained to do, other types of work. There are two classes of permanent partial disabilities: "Schedule" injuries—those specific injuries listed in the law, such as the loss of an arm, leg, eye, or other member of the body; and "nonschedule" injuries, which are those of a more general nature, such as a disability caused by injury to the head or back.

Table 8 shows minimum and maximum benefits for both schedule and nonschedule injuries. It shows the maximum percentage of wages or wage loss on which the benefits are computed. That is, for schedule injuries the benefits are usually based on average weekly wages, and for nonschedule injuries on the basis of "wage loss"—that is, the difference between wages before injury and wages after injury. The maximum payments per week shown in the table apply, as a rule, to both kinds of permanent partial disability, and the same is true of the maximum totals in the last column of the table. Where there are different maximums for schedule and nonschedule, this is indicated on the table.

[2] Alabama, Arizona, Idaho, Illinois, Iowa, Massachusetts, Michigan, Montana, Nevada, North Dakota, Oregon, Rhode Island (if not receiving temporary disability insurance), Utah, Vermont, Washington, and Wyoming.

[4] Connecticut: Beginning October 1963, the maximum amounted to $57 a week.
[5] In case total disability begins after a period of partial disability, the period of partial disability sha be deducted from the specified period for temporary total.
[6] Massachusetts: Maximum $18,000 for temporary total and permanent partial disability.
[7] Michigan: Total maximum may not exceed 500 times total weekly amount payable.
[8] New Jersey: Benefits are set in accordance with a "wage and compensation schedule." Under this schedule, the 66⅔-percent level is adhered to fairly closely for workers earning wages of $45 a week or less. For workers who earn more, the schedule specifies benefits which are less than 66⅔ percent. For instance, a worker earning $60 a week is entitled to a compensation benefit of $36, or 60 percent.
[9] North Carolina: The 400 weeks and $12,000 do not apply in cases of permanent total disability resulting from an injury to the brain or spinal cord or from loss of mental capacity caused by an injury to the brain.
[10] Rhode Island: After 1,000 weeks, or after $16,000 has been paid, payments to be made from 2d injury fund for period of disability. The allowance of up to $12 a week for dependent children is also payable from this fund.

TABLE 8.—*Minimum and maximum benefits for permanent partial disability* [1]

State	Maximum percentage of wages or wage loss [2]	Maximum period for nonschedule injuries	Payments per week [3]		Total maximum stated in law [3]
			Minimum	Maximum	
Alabama	55–65 [4]	300 weeks	$15, or actual wage if less (schedule). No statutory minimum for nonschedule.	$38	
Alaska	65	During disability	$25	$100	$20,000 (schedule), $17,000 (nonschedule).
Arizona	55	During disability [5]	$25.38 if worker is 21 years of age or older.	$126.92	
Arkansas	65	450 weeks	$7	$35	$12,500.
California	61¾ [6]	399 weeks [7 8]	$20	$52.50	
Colorado	66⅔	During disability [7 9]	$10 [9]	$43.75 [9]	$11,376 (nonschedule). [9]
Connecticut	60	780 weeks [7]	$20 (schedule). No statutory minimum for nonschedule.	55 percent of State's average production wage ($57).	
Delaware	66⅔	300 weeks [7]	$25, or actual wage if less	$50	
District of Columbia	66⅔	During disability [7]	$18 or average wage if less (schedule). No statutory minimum for nonschedule.	$70	$24,000.
Florida	60	350 weeks [6]	$8, or actual wage if less	$42	
Georgia	60	350 weeks [4]	$10, or actual wage if less (schedule). No minimum for nonschedule.	$30	$9,000 (nonschedule).
Hawaii	66⅔	During disability [7]	$35	$112.50	$25,000 (nonschedule).
Idaho	60	In proportion to schedule injuries. [7]	$15, or average wage if less	$30	
Illinois	65–80 [4]	417.43 weeks (8 years) [7]	$31.50 to $49 [4]	$51 to $61 [4]	$13,500 to $17,500. [4]
Indiana	60	500 weeks [7]	$18	$42	$16,500.
Iowa	66⅔	In proportion to permanent total disability, for which the maximum is 500 weeks. [7]	$18, or actual wage if less	$37	$18,500.
Kansas	60	415 weeks	No statutory minimum	$42	$17,430.
Kentucky	66⅔	400 weeks [10]	25 percent of 85 percent of the State's average weekly wage.	50 percent of 85 percent of the State's average weekly wage.	
Louisiana	65	300 weeks	$10, or actual wage if less	$35	
Maine	66⅔	300 weeks	No statutory minimum	$42	
Maryland	66⅔	During disability [7]	$15, or actual wage if less	$25	$12,500.
Massachusetts	100	During disability	No statutory minimum	$53, plus $6 for each dependent (aggregate shall not exceed the average weekly wage of the employee). $20 in addition to all other benefits for schedule injuries.	$18,000. [11]

See footnotes at end of table, p. 933.

TABLE 8.—*Minimum and maximum benefits for permanent partial disability* [1]—Continued

State	Maximum percentage of wages or wage loss [2]	Maximum period for nonschedule injuries	Payments per week [3]		Total maximum stated in law [3]
			Minimum	Maximum	
Michigan	66⅔	500 weeks	No statutory minimum	$33 to $57 [4]	
Minnesota	66⅔	350 weeks [7]	$17.50	$45	
Mississippi	66⅔	450 weeks [7]	$10 (schedule)	$35	
Missouri	66⅔	400 weeks [7]	$16	$42.50	
Montana	50–66⅔ [4]	500 weeks	$25.50 (schedule). No statutory minimum for nonschedule.	$29 to $50	
Nebraska	66⅔	300 weeks [5]	$26, or actual wage if less (schedule). No statutory minimum for nonschedule.	$40	
Nevada	50	429 weeks [7]	$13.85	$23.08	
New Hampshire	66⅔	341 weeks [5]	$20, or average wage if less	$43.50 (schedule) $45.00 (nonschedule)	$14,322.
New Jersey	(12)	550 weeks [7]	$10	$40	
New Mexico	60 (schedule). Percentage as determined by the court (nonschedule).	500 weeks [8]	No statutory minimum	$40 (schedule)	$19,000.
New York	66⅔	During disability	$20, or actual wage if less	$55	
North Carolina	60⅔	300 weeks	$10 (schedule). No statutory minimum for nonschedule.	$37.50	$12,000.
North Dakota	66⅔	450 weeks	$31.50	$31.50	
Ohio	66⅔	(13)	$25 (schedule), or full wages if less. No statutory minimum for nonschedule.	$49	$10,000 under A.[13]
Oklahoma	66⅔	500 weeks	$15, or actual wage if less	$37.50	
Oregon	50–75 [4]	In proportion to schedule injuries.[7]	$23.08	$32.31 to $66.92 [4 14]	$6,742.50 (nonschedule).
Pennsylvania	66⅔	350 weeks [7]	$25, or 90 percent of wages if less, but not less than $17.50 (schedule). No statutory minimum for nonschedule.	$47.50 (schedule) $37.50 (nonschedule)	
Puerto Rico	66⅔	450 weeks [7]	$8	$35	$6,000.
Rhode Island	50 (schedule) 60 (nonschedule)	800 weeks	$16 (schedule). No statutory minimum for nonschedule.	$30 (schedule) $22 (nonschedule)	
South Carolina	60	300 weeks [7]	$5 (schedule). No statutory minimum for nonschedule.	$35	$10,000.
South Dakota	55	312 weeks [7]	$20, or average wage if less (schedule). No statutory minimum for nonschedule.	$38	$13,500

Tennessee	65	400 weeks [7]	$15, or average wage if less, but in no event less than $12.	$36	$14,000.
Texas	60	300 weeks [7]	No statutory minimum	$35	
Utah	60	312 weeks [8]	No statutory minimum	$40 to $54.25 [9]	$8,978.[16]
Vermont	66⅔ (nonschedule).	330 weeks [17]	$20, or average wage if less	$39	$12,870.
Virginia	60	300 weeks [8] [7]	$14 (schedule). No statutory minimum for nonschedule.	$39	$15,600.
Washington		In proportion to schedule injuries.	No statutory minimum	In proportion to schedule injuries	$8,750 (nonschedule).
West Virginia	66⅔	335 weeks [8] [18]	$22	$38	
Wisconsin	70	1,000 weeks [7]	$14	$44.50	
Wyoming		In proportion to schedule injuries. [7]	$20.77 to $25.38 according to marital status.	$20.77 to $25.38 according to marital status.	
United States:					
Federal employees	66⅔–75 [4]	During disability [7]	$41.54, or actual wage if less (schedule). No statutory minimum for nonschedule.	$121.15	
Longshoremen	66⅔	During disability [7]	$18 or average wage if less (schedule). No statutory minimum for nonschedule.	$70	$24,000.

[1] In some States the benefits listed do not apply if the disability is due either to silicosis or to any occupational disease. (See p. 38.)

[2] Generally for schedule injuries percentage is figured on average weekly wages, and for nonschedule injuries on the basis of the difference between wages before injury and wages after injury.

[3] Figure given is the amount paid for both schedule and nonschedule injuries unless otherwise noted.

[4] According to number of dependents. In Illinois, according to number of dependent children under 16, or under 18 when not emancipated. Under the Federal Employees' Compensation Act, the 75 percent of wages is contingent upon the existence of a statutory dependent.

[5] In case the partial disability begins after a period of total disability, the period of total disability shall be deducted from the total period set in the law for partial disability.

[6] The California law provides for 65 percent of 95 percent of actual earnings, or 61¾ percent.

[7] In addition to compensation for temporary total disability, which is limited in some States to a specific number of weeks.

[8] California: 4 weeks of compensation for each 1 percent of permanent disability, and thereafter if disability is 70 percent or more, life pension of 1.5 percent of average weekly earnings for each percent of disability in excess of 60 percent.

[9] Colorado: If periodic disability benefits are payable to the worker under the Federal OASDI, the workman's compensation weekly benefits shall be reduced (but not below zero) by an amount approximating ½ such Federal benefits for such week. If disability benefits are payable under an employer pension plan, the workmen's compensation benefits shall be reduced in an amount proportional to the employer's percentage of total contributions to the plan.

[10] Kentucky: Where compensation is paid for other types of disability, the period of such payments is deducted from the 400 weeks.

[11] Massachusetts: $18,000 is the maximum for temporary total and permanent partial disability.

[12] New Jersey: Benefits set in accordance with a "wage and compensation schedule." Under this schedule, the 66⅔ percent level is adhered to fairly closely for workers earning wages of $45 a week or less. For workers who earn more, the schedule specifies benefits which are less than 66⅔ percent. For instance, a worker earning $60 a week is entitled to a compensation benefit of $36, or 60 percent.

[13] Ohio: Employee may elect benefits under 1 of 2 plans: "A" under which benefits are based on permanent physical impairment. Under "B" benefits are paid for a maximum of 200 weeks if disability is 90 percent or more, and are set at 66⅔ percent of employee's average weekly wage.

[14] Oregon: Schedule permanent partial injuries are compensated at the rate of $46.50 for each degree of disability, as specified in the law, but maximum weekly payments are limited to those shown in his table.

[15] Rhode Island: If employee cannot obtain suitable work and employer cannot give him such work or show it is available elsewhere, weekly benefits for partial incapacity are paid at the same rate as for total incapacity ($45 maximum).

[16] Utah: The maximum $8,987 applied in cases of occupational disease, the maximum benefits are $4,309.

[17] Vermont: In case the partial disability begins after a period of total disability no deduction for the period of total disability is made unless the combination of both periods exceeds the statutory maximum of 330 weeks. In no case can the combined total of all types of compensation exceed the 330 weeks. (*Orris* v. *Hutchins*, 123 Vt. 18.)

[18] West Virginia: For a disability of 55 to 100 percent, benefits are payable during life.

The benefits shown on this table apply in cases of disability due to accidental injury. In the following States, lower or sometimes no benefits are payable for permanent partial disability due to silicosis, or in some cases to any occupational disease: Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Utah, and Vermont.

The maximum periods shown on table 8 for payment of benefits are for nonschedule injuries.[8] In Arizona, New York, and under the Federal employees' act, in cases of nonschedule injuries, benefits are paid for the period of disability, with no limitation on the number of weeks or the total maximum benefits. Under seven other laws (Alaska, Colorado, District of Columbia, Hawaii, Maryland, Massachusetts, and the longshoremen's act), there are no limitations on the number of weeks, but the maximum monetary benefits are limited. Four States—Idaho, Oregon, Washington, and Wyoming—pay in proportion to the amount allowed for certain schedule injuries, and one, Iowa, in proportion to permanent total benefits. Under the remaining laws, there is a specific number of weeks for which payments may be made, ranging from 300 to 1,000 weeks. Where there are maximum monetary benefits, they range from $6,000 to $25,000.

Additional benefits for dependent children are granted workers suffering permanent partial disability (either schedule, nonschedule, or both) in eight States: Alabama, Illinois, Massachusetts, Michigan, Montana, Oregon, Utah, and Wyoming.

Period of compensation payments for schedule injuries.—Table 9 shows the number of weeks for which benefits are payable for certain schedule injuries under each of the 54 laws. The principle underlying this method of payment is that it is to the advantage of the worker to provide a known period within which he can adjust himself to his handicap and to recover his place in industry. In about half of the workmen's compensation laws, there are provisions for rehabilitation in the form of retraining, education, placement, and job guidance to help the injured person find suitable work before the period of compensation runs out.

As shown in table 9, the laws of 46 States, as well as those of the District of Columbia, Puerto Rico, and the Federal employees' and longshoremen's acts, have established schedules stating the number of weeks during which compensation shall be paid for schedule or specified injuries.

Under the laws of the remaining four States, the payments are determined by other methods. In Alaska, Washington, and Wyoming, the law provides for fixed sums for each schedule injury. In Oregon, the law sets $46.50 for each degree of injury, and each injury is assigned a certain number of degrees.

The monetary benefits for these injuries are determined by using tables 8 and 9 together, table 8 giving the maximum weekly benefits payable and table 9 the number of weeks for which payments are made.

The table also shows variations in the meaning of certain terms. For instance, in providing payments for loss or loss of use of an arm at the shoulder, some laws specify only loss or loss of use of an arm; others specify that the loss at the elbow is the same as loss at the shoulder. A few pay the same compensation for loss of an arm anywhere above the wrist as for loss at the shoulder. These variations, and similar provisions for loss of leg, appear on table 9. However, where a different period of time is set for loss of an arm at the elbow, as is the case in a few jurisdictions, this figure is not shown on the table. The table also shows certain variations for loss of fingers and toes. However, not all, but only major, variations in the laws are indicated on the table. Where there is a difference between hand, and hand and wrist combined,

[8] See table 9 for the number of weeks that payments are made for certain schedule injuries.

the number of weeks for the latter is shown on the table. Similarly if the figures are different for a foot, and a foot and ankle combined, the latter figure is used.

As can be seen from the table, there are wide differences from State to State in time payments for the various specific injuries. For example, for the loss of an arm at the shoulder, which is usually considered the most serious single loss of a member, most States provide payments for between 200 and 300 weeks, but in Wisconsin the payments are for 500 weeks. However, the number of weeks alone does not tell the whole story. The actual amount received varies substantially. Examples of the benefit payment for loss of an arm are $7,350 in Maine, $14,000 in Montana, and $22,250 in Wisconsin. Some States set different rates for a "major" and a "minor" member, depending upon whether a worker is right or left handed.

Another example is the loss of hearing. A few laws do not set specific benefits for this type of disability. Where loss of hearing in one ear is covered, examples of maximum payments are $1,225 in Ohio, $2,700 in Alaska, $3,150 in Indiana, and $5,850 in Hawaii. For loss of hearing in two ears, Nebraska pays $4,000; Alabama, $6,194; the District of Columbia, $14,000; and Arizona, $32,999. This pattern of variations among the States is true for all the different schedule injuries, but the jurisdictions paying the lowest or highest amount for one injury may not necessarily do the same for each type of injury.

Loss of sight in both eyes is not shown in the table as a schedule injury, because in almost every purisdiction this is considered a permanent total disability, as are loss of both legs, both arms, one hand, and one foot, and similar disabilities.

Under most laws, the compensation for permanent partial disability is in addition to all or part of the healing period. In most laws additional amounts are allowed for disfigurement, although this is not shown on the table. In many cases, the disfigurement is compensable only if it interferes with present or future earning capacity. Over a third of the States limit disfigurement to discernible head or facial injuries. The maximum payment set in the law for disfigurement varies considerably from State to State, ranging from $500 to $7,000.

PERMANENT TOTAL DISABILITY

Persons having a permaent total disability are presumed to be unable to work at all, or unable to work regularly in anly well-known branch of the labor market. As mentioned above, permanent total disability also includes the loss of both eyes, both legs, or both arms, as well as other types of disability specified in the various laws. Benefits for workers suffering such disability are shown in table 10. This table lists the percentage of wages payable, the period during which payments are made, limitations on minimum and maximum weekly payments, and the maximum total amount stated in the law.

The trend in the payment of permanent total benefits is unquestionably toward payment for the entire period of disability. Thirty-three laws now have this provision. These are the two Federal laws, and those of the following jurisdictions:

Alaska
Arizona
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Hawaii
Idaho
Illinois
Indiana
Massachusetts
Michigan
Minnesota
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New York
North Dakota
Ohio
Oregon
Pennsylvania
Puerto Rico
Rhode Island
Utah
Washington
West Virginia
Wisconsin

TABLE 9.—*Number of weeks for which compensation is payable for certain schedule injuries**

[Monetary weekly benefits shown on table 8]

State	Loss or loss of use of—													
	Arm (at shoulder)	Hand	Thumb	1st finger	2d finger	3d finger	Little finger	Leg	Foot	Great toe	Other toe	Sight of an eye	Hearing, 1 ear	Hearing, both ears
Alabama [1]	222	170	62	43	31	22	16	200	139	32	11	124	53	163
Alaska [2 3]														
Arizona [2]	[4] 260 [5] 217	[4] 217 [5] 173	65	39	30	22	17	217	173	30	11	[9] 130 [7] 108	87	260
Arkansas [2]	[5] 200	150	60	35	30	20	15	[9] 175	125	30	10	100	40	150
California [2 10]	[4] 300 [5] 280	[4] 280 [5] 260	[4] 48 [5] 44	[4] 32 [5] 28	[4] 32 [5] 28	[4] 24 [5] 20	[4] 24 [5] 20	[10] 320 [11] 280	140	40	8	[9] 120 [7] 100	40	200
Colorado [2]	208	104	[12] 50 [12] 35	[12] 26 [12] 18	[12] 18 [12] 13	[12] 11 [12] 7	[12] 13 [12] 9	[14] 208 [11] 130	104	[12] 26 [12] 18	[12] 11 [12] 4	[9] 139 [7] 104	35	139
Connecticut [2]	[4] [5] 296 [5] 291	242	87	54	44	31	26	[9] 238	188	42	13	235	52	156
Delaware [2]	[5] 250	220	75	50	40	30	20	250	160	40	15	200	75	175
District of Columbia [2]	[6] 312	244	75	46	30	25	15	[9] 288	205	38	16	160	52	200
Florida [2]	[5] 200	175	60	35	30	20	15	[9] 200	175	30	10	175	40	150
Georgia [2]	200	160	60	40	35	30	25	225	135	30	20	125	60	150
Hawaii [2]	312	244	75	46	30	25	15	[9] 238	205	38	16	[6] 160 [7] 140	52	200
Idaho [2]	240	200	[12] 70 [12] 40	[12] 40 [12] 35	[12] 40 [12] 30	[12] 30 [12] 20	[12] 20 [12] 15	[14] 180 [11] 150	125	[12] 30 [12] 15	[12] 12 [12] 6	[6] 140 [7] 120	35	150
Illinois [2]	[13] 300	190	70	40	35	25	20	[13] 275	155	35	12	[6] 150 [7] 140	50	125
Indiana [2]	[5] 275	200	60	40	35	30	20	[9] 275	175	60	[16]	175	75	200
Iowa [2 17]	230	175	60	35	30	25	20	[9] 200	150	40	15	125	50	175
Kansas [18]	210	150	60	37	30	20	15	[9] 200	125	30	10	120	30	110
Kentucky [2]	200	150	[12] 70 [12] 60	[12] 55 [12] 45	[12] 40 [12] 30	[12] 30 [12] 20	[12] 25 [12] 15	200	125	30	10	[6] 120 [7] 100	75	150
Louisiana [1]	200	150	50	30	20	20	20	[9] 175	125	20	10	100		
Maine [19]	[5] 175	150	50	32	28	20	17	[9] 175	150	25	10	[20] 100	50	100
Maryland [2]	[5] 252	196	50	30	25	20	15	[9] 252	175	25	10	200	75	175
Massachusetts [21]	[4] [5] 225 [5] [8] 200	[4] [5] 175 [5] [8] 150						[9] 200	150			[6] 200	150	400
Michigan	[5] 269	215	65	38	33	22	16	[9] 215	162	33	11	162		
Minnesota [2]	[5] 270	220	65	40	35	25	20	[14] 220 [11] 195	165	35	15	160	55	170
Mississippi [2]	[5] 200	150	60	35	30	20	15	[9] 175	125	30	10	100	40	150

Missouri [2] [22]	232	175	60	45	35	35	22	[14] 207 [11] 150	150	40	14	140	44	168
Montana [1]	280	200	[12] 75 [12] 37	[12] 75 [12] 30	[12] 37 [12] 20	[12] 25 [12] 15	[12] 15 [12] 11	[14] 300 [11] 200	180	[12] 37 [12] 18	[12] 16 [12] 8	[6] 165 [7] 140	40	200
Nebraska [2]	[5] 225	175	60	35	30	20	15	[9] 215	150	30	10	125	50	100
Nevada [2]	[4] 260 [5] 216	[4] 216 [5] 173	65	39	30	22	17	[9] 216	173	30	11	[5] 216 [7] 173	87	260
New Hampshire [2]	[5] 214	175	50	21	26	19	13	[9] 214	151	26	10	126	52	214
New Jersey [2]	[5] 300	230	75	50	40	30	20	[9] 275	200	40	15	[6] 225 [7] 200	60	200
New Mexico [2]	[4] 200 [5] 175	[4] 125 [5] 110	[12] 55 [12] 34	[12] 28 [12] 22	[12] 22 [12] 17	[12] 17 [12] 12	[12] 14 [12] 14	[14] 200 [11] 150	115	[12] 35 [12] 17	[12] 14 [12] 10	[6] 130 [7] 120	40	150
New York [22]	312	244	75	46	30	25	15	288	205	38	16	160	60	150
North Carolina [2]	220	170	65	40	35	22	16	200	144	35	10	120	70	159
North Dakota	250	[4] 250 [5] 200	[6] [12] 93.75 [4] [12] 81¼ [5] [12] 75 [5] [12] 65	[6] [12] 62½ [4] [12] 50 [5] [12] 50 [5] [12] 40	[6] [12] 50 [4] [12] 37½ [5] [12] 40 [5] [12] 30	[6] [12] 37½ [4] [12] 25 [5] [12] 30 [5] [12] 20	[6] [12] 32½ [4] [12] 20 [5] [12] 26 [5] [12] 16	[24] 234 [24] 195	150	30	12	150	50	200
Ohio [2]	225	175	60	35	30	20	15	200	150	30	10	125	25	125
Oklahoma [1]	[5] 250	200	60	35	30	20	15	[9] 175	150	30	10	100	100	200
Oregon [23]														
Pennsylvania [2]	[5] 215	175	60	35	30	20	15	[9] 215	150	40	16	150		180
Puerto Rico [2]	[5] 300	[4] 200 [5] 180	75	40	30	25	15	[14] 300 [11] 250	175	30	15	[26]	50	200
Rhode Island [2]	[5] 312	244	75	46	30	25	20	[9] 312	205	38	10	160	60	200
South Carolina [1]	200	150	60	35	30	20	15	175	125	30	10	100	70	150
South Dakota [2]	[5] 200	150	50	35	30	20	15	[9] 160	125	30	10	150		
Tennessee [2]	[5] 200	150	60	35	30	20	15	[9] 175	125	30	10	100		150
Texas [1]	[5] 200	150	[12] 70 [12] 60	[12] 55 [12] 45	[12] 40 [12] 30	[12] 31 [12] 21	[12] 25 [12] 15	[9] 200	125	30	10	100	[27] 75	150
Utah [2]	200	150	[12] 60 [12] 30	[12] 30 [12] 20	[12] 30 [12] 15	[12] 20 [12] 12	[12] 12 [12] 9	[4] 180 [11] 150	125	[12] 30 [12] 15	[12] 12 [12] 6	[6] 120 [7] 100	50	200
Vermont [2]	[5] 215	175	50	32	25	20	12	[9] 215	175	25	10	125	[28] 52	215
Virginia [1]	200	150	60	35	30	20	15	175	125	30	10	100	50	100
Washington [29]														
West Virginia	240	200	80	40	28	20	20	[30] 240 [30] 200	140	40	16	132	60	180
Wisconsin [31]	500	400	[12] 125 [12] 100	[12] 60 [12] 50	[12] 45 [12] 35	[12] 26 [12] 20	[12] 28 [12] 22	[32] 500 [32] 425	250	[12] 83⅓ [12] 25	(33)	[6] 275 [7] 250	[31] 50 [31] 36	[31] 333½ [31] 216
Wyoming [34]														

See footnotes at end of table, p. 938.

TABLE 9.—*Number of weeks for which compensation is payable for certain schedule injuries**—Continued

[Monetary weekly benefits shown on table 8]

State	Loss or loss of use of—												
	Arm[5] (at shoulder)	Hand	Thumb	1st finger	2d finger	3d finger	Little finger	Leg	Foot	Great toe	Other toe	Sight of an eye	Hearing, 1 ear	Hearing, both ears
United States:														
Federal employees [3]	[8] 312	244	75	46	30	25	15	[9] 288	205	38	16	160	52	200
Longshoremen [3]	[8] 312	244	75	46	30	25	15	[9] 288	205	38	16	160	52	200

*Some States include additional injuries in their schedules, such as loss of testicles or skull fracture or other bone fractures.

[1] Payments under this schedule are in lieu of all other payments.

[2] Alaska: Law provides for payment of fixed sums for schedule injuries. For instance, for the loss of an arm, $14,500; loss of a leg, $12,900; loss of an eye, $7,200; loss of hearing in 1 ear, $2,700.

[3] Payments are in addition to payments for temporary total disability during all of part of the healing period.

[4] For major member.

[5] For minor member.

[6] By enucleation.

[7] Without enucleation.

[8] Loss at shoulder or elbow. In Minnesota and South Dakota, amputation of arm below elbow considered loss of arm if artificial member cannot be used. In Delaware, the District of Columbia, Illinois, Maine, Mississippi, Tennessee, and under the Federal employees' and longshoremen's acts, loss of arm above the wrist shall be considered as loss of arm.

[9] Loss of leg at hip or knee. In Delaware, the District of Columbia, Maine, Mississippi, and Tennessee, and under the Federal employees' and longshoremen's acts, loss of leg above ankle considered as loss of leg.

[10] California: Ratings vary, based on age and occupation of employee. Figures given are standard ratings, prior to modification for occupation and age. The figures shown for arm, leg, and foot are for cases where reasonably satisfactory use of prosthesis is not possible. Where prostheses can be used, the following figures apply: major arm—280 weeks, minor arm—260 weeks; major hand—240 weeks, minor hand—220 weeks; leg at or above knee, 260 weeks. In case of loss of an arm, or the major hand, or a leg, if reasonably satisfactory use of prothesis is not possible, after receiving benefits for the schedule period the employee is given a life pension of 15 to 30 percent of average weekly earnings.

[11] Loss of leg at or above knee if use of artificial limb possible.

[12] Loss of metacarpal bone in case of a thumb or finger, or metatarsal bone in case of a toe.

Loss at proximal joint.

[14] Loss at hip joint, so close as to preclude use of artificial limb.

[15] Illinois: 235 weeks for loss of arm. If amputation is above elbow, 15 additional weeks is allowed. If arm is amputated so close to the shoulder joint that an artificial arm cannot be used, or if arm is disarticulated at the shoulder joint, an additional 65 weeks (a total of 300) is allowed. 200 weeks for loss of leg. If amputation is above knee, 25 additional weeks. If leg is amputated so close to hip joint that an artificial limb cannot be used, or if leg is disarticulated at the hip joint, an additional 75 weeks (a total of 275) is allowed.

[16] Indiana: For loss of 2d toe, 30 weeks; 3d toe, 20 weeks; 4th toe, 15 weeks; and 5th toe, 10 weeks.

[17] Iowa: In addition to maximum weeks, the law sets monetary maximums for schedule injuries: loss of arm, $8,500; hand, $6,500; thumb, $2,225; 1st finger, $1,300; 2d finger, $1,110; 3d finger, $920; little finger, $740; leg, $7,360; foot, $5,520; great toe, $1,280; other toe, $560; sight of an eye, $4,600; loss of an eye if other eye already lost, $7,360; hearing, 1 ear, $1,850; hearing, both ears, $6,500

[18] Kansas: Payments are in lieu of all other benefits, except that in certain cases additional compensation may be allowed during the healing period for not to exceed 10 percent of the schedule period, maximum 15 weeks.

[19] Maine: The incapacity is deemed to be total for the period given in the schedule. After the specified period, if there is actual partial or total incapacity, benefits for such incapacity shall be paid. (See tables 8 and 10.)

[20] Maine: Or for diplopia.

[21] Massachusetts: A flat sum of $20 weekly is payable for the specific periods listed. This is in addition to all other benefits. Loss or loss of use of fingers and toes is in proportion to loss of hand or foot.

[22] Missouri: If schedule loss (with the exception of an eye) is 100 percent, either by severance or loss of use, weeks of compensation are increased by 10 percent.

[23] New York: If healing period exceeds the specified time, the protracted period beyond such time is awarded in addition to the schedule loss incurred.

[24] North Dakota: Loss of leg at hip, 234 weeks; at knee, 195 weeks.

[25] Oregon: In addition to payments for temporary total disability, law provides for payment of $46.50 for each degree of injury. For instance, for loss by separation of 1 arm

at or above elbow joint 192 degrees or $8,928; loss by separation of 1 leg above knee, 150 degrees or $6,975. Complete loss of hearing, 1 ear, $2,790; both ears, $8,928. Complete loss of sight, 1 eye, $4,650. Partial loss of hearing, or partial loss of sight, 1 eye, apportioned to above maximums, partial loss of sight, both eyes, to 300 degrees of disability $13,950).

[28] Puerto Rico: Permanent visual disabilities are to be determined by the manager of the State insurance fund.

[29] Texas: The industrial accident board allows 75 weeks for loss of hearing in 1 ear.

[30] Vermont: In lieu of all other benefits except medical and hospital benefits.

[31] Washington: Law provides for payment of fixed sums for specified injuries, which are in addition to payments for temporary total disability. For instance, for amputation of 1 leg at the hip, $9,750, amputation of arm so near the shoulder than an artificial arm cannot be worn, $9,750, major arm at or above elbow, $8,250, loss of 1 eye by enucleation, $4,875; complete loss of hearing in both ears, $6,825.

[32] West Virginia: Loss of thigh at hip joint, 240 weeks; loss of thigh, 200 weeks.

[33] Wisconsin: In addition to payments for temporary total disability. Periods during which payments are made for schedule injuries are based upon employee who is 50 years of age or less. Where employee is above 50, periods specified reduced by 2½ percent for each year the age of such employee exceeds 50.

[34] Wisconsin: Loss at hip joint, 500 weeks; at knee, 425 weeks. For loss of 2d toe, 25 weeks, or 8 weeks for loss at proximal joint; other toes, 20 weeks, or 6 weeks for loss at proximal joint. For deafness due to accident or sudden trauma: 1 ear 50 weeks; 2 ears 333⅓ weeks; for total occupational deafness caused by exposure to noise in employment: 1 ear 36 weeks; 2 ears 216 weeks.

[35] Wyoming: In addition to payments for temporary total disability, law provides for payment of fixed sums for schedule injuries. For instance, for loss of arm above elbow, $6,000; for the loss of a leg above knee, $5,280; for loss of an eye or at least 90 percent of the sight thereof, $5,000. (No provision for loss of hearing.)

TABLE 10.—*Minimum and maximum benefits for permanent total disability*

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
Alabama	[1] 55–65	400 weeks. (For specific types of disability, 500 weeks.)	$15, or actual wage if less	$38	$15,200
Alaska	65	Duration of disability	$18, or actual wage if less	$52.65	
Arizona	65	Life	$30 if worker is 21 years of age or older	$150	
Arkansas	65	450 weeks	$7	$35	12,500
California	[2] 61¾	400 weeks; thereafter 60 percent of average weekly earnings at time of injury, for life.	$20	$52.50	
Colorado	66⅔	Life [3]	$10 [3]	$43.75 [3]	([3])
Connecticut	60	Duration of disability	$20	55 percent of State's average production wage ($57).	
Delaware	66⅔	....do	$25, or actual wage if less	$50	
District of Columbia	66⅔	....do	$18, or average wage if less	$70	
Florida	60	....do	$8, or actual wage if less	$42	
Georgia	60	400 weeks	$12, or actual wage if less	$37	12,500
Hawaii	66⅔	Duration of disability	$18	$75	([4])
Idaho	[1] 55–60	400 weeks; [5] thereafter $15 per week ($18 if dependent wife) plus $4 to $15 for children, for duration of disability.	$15 ($18 if dependent wife) to $33 [1]	$32 to $52 [1] (see col. 3)	
Illinois	[1] 65–80	Life	$31.50 to $49	$51 to $61	([6])
Indiana	60	500 weeks; thereafter payments may be made for an indefinite period.[7]	$18	$42	[7] 16,500
Iowa	66⅔	500 weeks	$18	$37	18,500
Kansas	60	415 weeks	$7	$42	17,430

TABLE 10.—*Minimum and maximum benefits for permanent total disability*—Continued

State	Maximum percentage of wages	Maximum period	Payments per week		Total maximum stated in law
			Minimum	Maximum	
Kentucky	66⅔	425 weeks [8]	25 percent of 85 percent of the State's average weekly wage.	55 percent of 85 percent of the State's average weekly wage.	
Louisiana	65	400 weeks	$10, or actual wage if less	$35	
Maine	66⅔	500 weeks	$18	$42	21,000
Maryland	66⅔	Duration of disability [9]	$18, or average wage if less	$48	30,000
Massachusetts	66⅔	do	$20	$53, plus $6 for each total dependent. Aggregate shall not exceed the average weekly wage of the employee.	
Michigan	66⅔	do [10]	$18 to $28 [1]	$33 to $57 [1]	
Minnesota	66⅔	do	$17.50, or actual wage if less	$45	(11)
Mississippi	66⅔	450 weeks	$10	$35	12,500
Missouri	66⅔	300 weeks, thereafter 40 percent of wages; maximum $27.50 for duration of disability.	$16	$42.50	
Montana	[1] 50–66⅔	500 weeks	$25.50	$29 to $50 [1]	
Nebraska	66⅔	300 weeks; thereafter 45 percent of wages; maximum $32 for duration of disability.	$26 or actual wage if less, 1st 300 weeks; thereafter $22 or actual wage if less.	$40. (see col. 3.)	
Nevada		Life	$37.50 to $51.92 [1]	$37.50 to $51.92 [1]	
New Hampshire	66⅔	312 weeks; thereafter annual extensions in the discretion of the labor commissioner.	$15, or actual wage if less	$45	
New Jersey	(12)	450 weeks; under certain conditions benefits paid for life.[12]	$10; after 450 weeks may be $5 [12]	$45 [12]	
New Mexico	60	500 weeks	$24, or actual wage if less	$38	20,000
New York	66⅔	Duration of disability	$20, or actual wage if less	$55	
North Carolina	60	400 weeks; 500 weeks for 2 injuries in same employment. (Payable for life in certain circumstances.[13])	$10	$37.50	[13] 12,000
North Dakota	80	Life	$15, plus $3 for each dependent child under 18, or those 18 and over incapable of self-support (up to a total of $15).	$45 to $60 [1]	
Ohio	66⅔	do	$40.25,[14] or average wage if less	$49	
Oklahoma	66⅔	500 weeks	$15, or actual wage if less	$37.50	
Oregon		Duration of disability	$28.25 to $63.46 [1]	$28.85 to $63.46 [1]	
Pennsylvania	66⅔	do	$27.50, or 90 percent of actual wage if less, but in no event less than $20.	$47.50	
Puerto Rico	66⅔	do	$9.23	$20.76	

South Carolina	60	500 weeks	$5	$35	10,000
South Dakota	55	300 weeks; thereafter 30 percent of earnings; maximum $15 for life.	$20, 1st 300 weeks; $12 thereafter	$38 (see col. 3)	13,500
Tennessee	65	550 weeks	$15, or average wage if less, but in no event less than $12.	$36	14,000
Texas	60	401 weeks	$9	$35	
Utah	60	260 weeks; thereafter 45 percent of weekly wages during disability; maximum $40.[16]	$25 to $39.25 [1]	$40 to $54.25 [1]	(15)
Vermont	66⅔	330 weeks [5]	$20, plus $2.50 for each dependent child under 21, or average wage if less.	$39, plus $2.50 for each dependent child under 21.	12,870
Virginia	60	500 weeks	$14	$39	15,600
Washington		Duration of disability	$38.08 to $71.54 [1]	$38.08 to $71.54 [1]	
West Virginia	66⅔	Life	$22	$38	
Wisconsin	70	do	$14	$64	
Wyoming			$28.85 to $34.62,[1] plus $5.54 for each dependent child under 18, or each child under 21 incapable of self-support because of mental or physical incapacity.[17]	$28.85 to $34.62,[1] plus $5.54 for each dependent child under 18, or each child under 21 incapable of self-support because of mental or physical incapacity.[17]	[1] [17] 12,000–19,000
United States:					
Federal employees	[1] 66⅔–75	do	$11.54, or actual wage if less	$121.15	
Longshoremen	66⅔	Duration of disability	$18, or average wage if less	$70	

[1] According to number of dependents. In Idaho, Oregon, Washington, and Wyoming, according to marital status and number of dependents. Under the Federal Employees' Compensation Act, the 75 percent of wages is contingent upon the existence of a statutory dependent.

[2] The California law provides for 65 percent of 95 percent of actual earnings, or 61¾ percent.

[3] Colorado: If periodic disability benefits are payable to the worker under the Federal OASDI, the workmen's compensation weekly benefits shall be reduced (but not below zero) by an amount approximating one-half such Federal benefits for such week. If disability benefits are payable under an employer pension plan, the workmen's compensation benefits shall be reduced in an amount proportional to the employer's percentage of total contributions to the plan.

Colorado does not limit total maximum for disability from accidental injury, but sets a maximum of $12,598.25 in case of occupational diseases.

[4] Hawaii: After $25,000 has been paid, compensation at the same rate is paid from a special fund.

[5] In case total disability begins after a period of partial disability, the period of partial disability shall be deducted from the weeks specified.

[6] Illinois: After $13,500 to $17,500, depending upon number of dependents, has been paid, a pension for life is provided.

[7] Indiana: After $16,500 and 500 weeks, further payments of compensation may be paid for an indefinite period from a special fund.

[8] Kentucky: If period of total disability begins after a period of partial disability, the period of partial disability shall be deducted from the 425 weeks.

[9] Law expressly provides that such payments are in addition to payments for temporary total.

[10] Michigan: Law states that there is a conclusive presumption that disability does not extend beyond 800 weeks, but after that time the question of permanent total disability is determined in each case in accordance with the facts.

[11] Minnesota: After $18,000 paid, OASDI benefits credited against workmen's compensation benefits.

[12] New Jersey: Benefits set in accordance with a "wage and compensation schedule." After 450 weeks, if worker has accepted such rehabilitation as may have been ordered by the rehabilitation commission, further benefits may be paid during disability, amounting to his previous weekly compensation payment diminished proportionately as the wages he is then able to earn bear to the wages received at the time of the accident. If his wages equal or exceed such former wages, his benefit rate shall be reduced to $5 a week.

[13] North Carolina: In cases in which total and permanent disability results from paralysis resulting from an injury to the brain or spinal cord or from loss of mental capacity resulting from an injury to the brain, compensation shall be paid during the life of the injured employee, without regard to the 400 weeks or to the $12,000 maximum.

[14] Ohio: For persons previously awarded permanent total disability benefits, supplemental payments may be made from the disabled workmen's relief fund to bring payment up to $40.25.

[15] Rhode Island: After 1,000 weeks, or after payment of $16,000, payments to be made for life from 2d-injury fund.

[16] Utah: After payment of $15,800 by the employer or carrier, a worker who has cooperated with the division of vocational rehabilitation but who cannot be rehabilitated receives from the combined injury fund 45 percent of wages for period of disability; weekly maximum $40.

[17] Wyoming: As to the allowance for the children, the law states: "* * * there shall be credited to the account of each of such children * * * a lump-sum equivalent to $24 per month ($5.54 per week) until the time when each of said children would become 18 years of age; provided that the lump sum credited to the account of all said children shall in no case exceed $7,000." The total maximum of $19,000 shown on the table includes the $7,000.

BEST AVAILABLE

Countrywide workmen's compensation statistics reported for private carriers and certain competitive State fund

State	Policy period	Death			Permanent, total			Major permanent, partial			Minor permanent, partial			Temporary, total		
		Number of cases	Indemnity	Medical	Number of cases	Indemnity	Medical	Number of cases	Indemnity	Medical	Number of cases	Indemnity	Medical	Number of cases	Indemnity	Medical
Alabama	1960-61	69	546,697	12,731	8	77,587	48,997	97	470,110	224,389	651	837,583	426,837	5,824	1,259,765	1,160,977
Alaska	1960-61	8	173,076	3,378	1	20,000	5,000	40	371,831	133,378	181	508,124	220,683	1,106	412,763	320,724
Arkansas	1960-61	77	773,916	21,798	7	104,689	75,311	139	696,385	253,491	1,130	1,612,813	757,883	5,019	1,080,714	960,027
California [1]	1960	676	10,056,357	277,529	50	3,022,937	2,158,559	3,465	33,822,615	11,496,550	21,743	50,459,236	17,327,088	60,294	16,774,944	12,876,274
Colorado [1]	1960-61	70	845,609	45,560	11	238,226	39,300	145	964,199	277,148	1,461	2,903,513	1,014,045	4,982	1,130,486	950,957
Connecticut	1960-61	54	1,370,955	21,211	4	135,876	121,719	209	1,656,795	630,384	3,232	4,886,704	1827,756	14,022	3,639,837	2,502,740
Delaware	1960	12	248,539	3,230				73	347,689	149,308	107	186,640	62,309	1,610	310,834	212,646
District of Columbia	1960-61	25	825,980	10,016	3	112,306	15,500	112	1,101,834	247,966	567	1,331,704	364,211	4,241	828,162	596,828
Florida	1960	163	1,699,758	90,438	12	365,199	281,125	518	3,180,464	1,348,307	2,932	5,342,767	2,420,750	21,209	6,285,156	5,016,795
Georgia	1960-61	138	1,113,641	28,792	16	101,691	29,579	255	1,231,562	365,292	1,530	2,036,486	762,996	9,872	2,372,021	1,887,095
Hawaii	1959-60	9	193,759	16,212	3	49,800	81,000	60	493,302	208,278	514	1,096,327	447,841	5,007	710,469	424,747
Idaho [1]	1960-61	43	400,179	12,728	2	8,165	3,786	21	134,990	99,597	438	624,474	302,016	3,360	808,069	675,260
Illinois	1960-61	248	2,723,684	121,128	36	811,995	896,809	1,146	7,232,571	1,893,644	15,858	20,210,084	4,804,241	22,974	10,397,332	4,403,312
Indiana	1960-61	140	1,718,829	33,731	10	123,214	63,794	320	1,877,884	648,020	2,456	3,766,246	1,365,534	11,151	3,248,564	2,251,838
Iowa	1960-61	92	792,428	37,577	9	93,358	56,215	104	532,144	194,912	804	1,250,132	579,386	6,143	1,547,357	1,459,550
Kansas	1960-61	106	993,901	41,469	12	115,463	36,559	295	1,774,152	405,852	1,493	2,826,872	802,968	5,030	2,116,595	1,104,814
Kentucky	1960-61	53	728,382	20,700	13	169,867	71,800	190	921,900	320,980	869	1,475,964	650,951	6,040	1,553,782	1,250,600
Louisiana	1959-60	257	2,824,507	111,157	92	1,019,507	282,115	1,176	7,855,698	2,000,984	4,057	8,511,351	2,634,967	22,867	10,346,768	5,406,321
Maine	1960-61	24	217,450	6,965	1	19,500	50,000	33	199,236	85,058	281	350,117	156,179	3,550	1,012,601	675,074

Maryland	1960-61	91	1,146,117	30,369	14	330,584	366,881	308	1,620,861	465,781	3,850	5,530,056	1,277,378	9,456	3,251,040	1,376,208
Massachusetts	1959-60	254	3,820,334	150,505	14	564,600	327,303	1,263	9,620,961	3,186,709	4,450	5,470,543	2,249,852	26,748	12,234,264	5,636,607
Michigan [1]	1960-61	238	3,122,753	109,349	22	467,807	279,964	597	4,374,472	1,473,579	1,677	3,676,645	1,457,727	20,625	10,578,102	7,067,383
Minnesota	1960	139	1,544,716	63,455	23	437,968	518,565	246	1,658,916	590,490	2,311	4,124,983	1,723,252	10,027	3,666,946	2,631,949
Mississippi	1959-61	123	1,010,698	33,892	9	98,285	149,650	330	1,313,671	585,428	1,350	2,538,611	987,326	9,278	2,161,023	1,663,011
Missouri	1960-61	128	1,508,012	55,293	18	481,172	420,065	379	2,039,557	662,537	5,034	7,002,234	1,897,934	13,617	4,211,780	1,958,079
Montana	1960-61	26	319,752	9,609	1	15,250	20,000	47	335,871	88,803	159	373,202	133,406	749	292,151	208,316
Nebraska	1960-61	62	608,409	10,263	9	111,917	30,659	87	529,659	248,039	603	966,351	406,919	3,240	895,646	714,786
New Hampshire	1960-61	11	116,302	4,506	1	13,640	2,500	49	316,163	188,193	310	505,475	238,658	3,581	971,593	718,066
New Jersey	1960	276	4,090,561	113,183	32	1,194,235	779,486	764	6,010,730	1,599,918	29,172	27,668,869	6,278,671	16,034	4,264,862	2,120,545
New Mexico	1960	62	817,139	25,033	6	114,000	61,100	210	1,332,596	492,366	1,020	1,706,008	687,457	2,912	964,332	649,822
New York [1]	1960	557	12,924,264	278,555	42	724,064	471,059	1,465	12,616,778	3,709,845	27,279	32,145,460	9,850,551	62,548	32,724,383	17,501,975
North Carolina	1960-61	130	1,211,336	25,492	9	198,938	170,987	284	1,257,828	485,184	2,634	2,953,405	1,029,449	12,149	2,567,210	1,866,088
Oklahoma [1]	1960-61	137	1,587,654	58,218	8	125,386	120,003	398	1,926,231	727,551	3,034	4,052,328	1,325,699	6,601	2,195,008	1,194,819
Pennsylvania	1960	288	3,653,535	134,625	57	771,661	129,992	1,262	6,796,403	2,249,256	1,546	1,940,907	722,966	30,474	7,332,959	6,346,125
Rhode Island	1960-61	11	97,814	12,870	3	40,090	14,000	80	526,416	268,693	386	779,725	360,169	4,693	1,793,830	1,199,849
South Carolina	1960-61	70	621,855	13,762	5	48,500	53,700	168	944,381	427,668	1,672	1,992,134	667,903	4,206	1,220,734	742,581
South Dakota	1960-61	11	94,817	1,987	4	47,955	64,231	15	99,829	50,316	125	201,859	102,552	744	171,603	163,823
Tennessee	1960-61	111	1,124,468	42,960	7	75,552	24,355	374	2,134,269	542,479	2,186	3,481,936	1,281,495	8,914	2,263,295	1,687,294
Texas	1961	490	4,992,563	272,025	87	1,019,151	1,333,609	2,878	14,749,184	4,345,311	15,094	18,229,478	6,398,295	32,890	11,178,101	641,634
Utah [1]	1960-61	40	395,487	28,983	1	14,116	40,000	81	327,013	158,303	205	299,879	170,095	3,680	513,094	474,857
Vermont	1960-61	9	88,640	2,806	1	11,890	15,000	28	188,553	97,272	239	336,180	170,421	1,372	450,135	309,325
Virginia	1960-61	70	615,630	23,586	5	67,425	53,220	166	1,035,772	315,087	1,560	1,772,166	792,900	10,647	2,262,147	2,011,362
Wisconsin	1960	105	1,535,272	60,908	6	154,814	87,952	188	1,948,605	590,535	2,562	5,136,684	2,072,399	17,185	3,560,657	2,509,452
Grand total		5,703	75,296,275	2,478,584	674	13,768,370	9,851,649	20,065	139,070,080	44,532,881	168,762	243,102,255	79,212,115	526,671	177,561,114	110,919,535

[1] Includes competitive State fund experience.

Two of these do not specify payments for the entire period: In Indiana, after the first 500 weeks and $16,500 maximum has been paid, further payments may be made for an indefinite period of time; and in New Hampshire, after 312 weeks annual extensions may be made in the discretion of the labor commissioner.

New Jersey pays for life providing that, after 450 weeks, the worker has accepted such rehabilitation as may have been ordered by the Rehabilitation Commission, and is still unable to earn wages equal to those earned before his accident. His benefits, however, are reduced after the 450-week period. Benefits are also reduced after a varying number of weeks in California, Idaho, Missouri, Nebraska, and Utah.

Eighteen of the thirty-three pay a maximum of $50 or more a week for the total period of disability: Alaska, Arizona, California, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Massachusetts, Michigan, Nevada, New York, North Dakota, Oregon, Utah, Washington, and Wisconsin.

An additional State, North Carolina, pays for life in cases in which total and permanent disability results from paralysis resulting from an injury to the brain or spinal cord or from loss of mental capacity resulting from an injury to the brain.

In the remaining 20 States, the payments are limited as to time, amount, or both. Two of these, Maryland and South Dakota, specify payments for life, but the laws set total monetary maximums. The time periods range from 330 to 550 weeks, and the money limitations from $10,000 to $30,000. Three of these States pay a maximum of $50 or more a week: Montana, Vermont, and Wyoming.

Some laws, including those of Hawaii, Nevada, Washington, and the Federal Employees' Act, provide additional payments for an attendant, if one is required.

In some States, the payments are different for single or married persons, or for workmen with dependents. For example, in Idaho the maximum weekly payment for a single employee is $32, while a married employee may receive $37 with $4 per week additional for each dependent child up to a total maximum of $52 a week. Illinois is an example of a State that makes no distinction between single and married employees, but provides additional amounts for dependent children. This State pays a maximum $51 a week for a single or a married worker, with additional payments for children up to a total of $61 a week.

Senator ANDERSON. I understood the Department of Labor had furnished us with one report showing that only 4 of the 50 States have maximum weekly benefits equal to two-thirds of the average monthly wage.

Do you agree with that statement?

Mr. KALMYKOW. Would you please repeat the statement?

Senator ANDERSON. This was furnished by the Department of Labor saying that in only 4 of the 50 States did the maximum weekly benefits equal two-thirds of the average weekly wage.

Mr. KALMYKOW. I don't know exactly the date of that statement, because there have been some considerable——

Senator ANDERSON. I don't, either. But have you got something greater than that?

Mr. KALMYKOW. Yes, I think we can show something greater than that.

Senator ANDERSON. Senator Douglas said we can get that from the Department of Labor and your figures. They said 5 States had average of less than 50 percent of the weekly wage; is that right?

Mr. KALMYKOW. I think it is a question, you have to examine the figures, as I say, and examine the dates. I think it is a question of

what average wage you take into consideration. Some of them have used the manufacturing wage which is higher than the level in general employment.

Our figures are based on people who are actually hurt in compensation cases, their actual wages at the time of injury, we keep very close track of that for rating in our own payment purposes.

Senator ANDERSON. I hope we can get the two figures together and see what they look like.

Mr. KEATING. Mr. Chairman, can we furnish those figures for the record?

Senator LONG. Yes.

AMERICAN INSURANCE ASSOCIATION,
New York, N.Y., May 19, 1965.

Congress H.R. 6675.

MRS. ELIZABETH B. SPRINGER,
Chief Clerk, Committee on Finance,
New Senate Office Building,
U.S. Senate, Washington, D.C.

DEAR MRS. SPRINGER: Pursuant to the request of the members of the Committee on Finance at the time of our appearance, I am pleased to enclose an up-to-date table which indicates a comparison between average take-home pay in each State and the maximum weekly workmen's compensation benefit for total disability payable in that State. I may say that a number of States are presently still considering workmen's compensation benefit legislation but have not yet taken final action with respect thereto.

The enclosed table also includes the full average weekly wage for each State as reported to the National Council on Compensation Insurance with respect to actual workmen's compensation claims paid by member companies. This data is furnished twice a year to the National Council in connection with their ratemaking functions.

I may add that bulletin No. 212, revised 1964 by the U.S. Department of Labor, pages 36–37, which I understand was referred to by some of the members of the committee makes reference to workmen's compensation benefit levels as of 1963. There have been a number of increases since that time. The comparison is to full average weekly wage with no reference to income tax or social security deductions. In some States that have additional payments for dependents the full allowance of such payment is not indicated. The average weekly wage used is in some instances somewhat higher then that earned by the average workmen's compensation claimant. It may tend to reflect wages of production workers in manufacturing which are somewhat higher.

The estimate as to the area of overlap furnished to us by the National Council on Compensation Insurance was based on figures of actual claims paid member companies classified by type of disability reported to the National Council for ratemaking purposes. To these were applied established percentages reflecting duration of disability. Consideration was also given to a special study made by one large carrier of workmen's compensation insurance made particularly for these hearings.

I trust this gives you the information requested. I have tried to rush this material to you because of the time limitations which you have indicated were in effect.

Sincerely yours,

ANDREW KALMYKOW, *Counsel.*

Enclosure.

(The figures referred to follow:)

Ratio of workmen's compensation benefits to weekly take-home pay

State	Average weekly wage [1]	Average weekly take-home pay [2]	Workmen's compensation maximum weekly benefit [3]	Compensation benefits percentage of take-home pay
National average	$89.76	$80.93	$53.71	66
Alabama	73.63	67.96	38.00	56
Alaska	149.00	130.10	100.00	77
Arizona	100.92	90.06	152.50	169
Arkansas	70.52	65.16	35.00	54
California	113.94	101.21	70.00	69
Colorado	96.45	86.55	43.75	51
Connecticut	98.63	88.35	59.00	67
Delaware	87.47	79.30	50.00	63
District of Columbia	96.19	86.30	70.00	81
Florida	75.07	69.05	42.00	61
Georgia	73.26	66.74	37.00	55
Hawaii	97.03	87.11	75.00	86
Idaho	90.44	81.56	[4] 52.00	64
Illinois	96.63	86.73	[4] 62.00	71
Indiana	87.10	78.94	45.00	57
Iowa	88.20	78.08	[4] 56.00	72
Kansas	90.25	81.38	42.00	52
Kentucky	80.72	73.59	41.00	56
Louisiana	84.90	77.12	35.00	45
Maine	72.97	67.32	42.00	62
Maryland	87.76	79.58	55.00	69
Massachusetts	92.66	83.50	[4] 71.00	85
Michigan	99.31	89.01	[4] 91.00	102
Minnesota	92.29	83.14	45.00	54
Mississippi	67.74	63.08	35.00	55
Missouri	88.09	79.60	47.50	60
Montana	93.34	83.08	[4] 56.00	64
Nebraska	85.56	77.76	40.00	51
Nevada	113.30	[5] 98.76	[4] 62.31	63
New Hampshire	76.68	70.40	45.00	64
New Jersey	93.88	84.68	45.00	53
New Mexico	98.90	88.61	40.00	45
New York	95.45	85.89	60.00	70
North Carolina	70.50	65.14	37.50	58
North Dakota	81.56	[5] 73.71	[4] 60.00	81
Ohio	104.13	[5] 91.68	56.00	61
Oklahoma	83.85	76.41	37.50	49
Oregon	97.04	[5] 85.81	[4] 73.85	86
Pennsylvania	93.05	83.88	47.50	57
Rhode Island	88.03	79.54	45.00	57
South Carolina	69.93	63.93	35.00	55
South Dakota	86.54	78.40	38.00	48
Tennessee	74.05	68.07	38.00	56
Texas	84.84	77.06	35.00	45
Utah	101.28	90.41	[4] 60.00	66
Vermont	75.02	69.00	[4] 47.00	68
Virginia	75.56	69.52	39.00	56
Washington	101.78	[5] 89.40	[4] 71.59	80
West Virginia	93.27	[5] 82.86	38.00	46
Wisconsin	92.66	83.50	64.00	77
Wyoming	95.25	[5] 84.37	[4] 60.00	71
Longshoremen's Act	[6]	[6]	70.00	

[1] Based upon wages of employees to whom compensation paid, July, 1964, National Council on Compensation Insurance.
[2] Average weekly wages less Federal income and social security taxes (4 deductions).
[3] As of May 1965. Includes maximum allowance for temporary total disability for worker with a wife and two children. (Illinois, Iowa, Michigan, New York, and Vermont reflect benefit increases contained in bills that have passed their legislatures.)
[4] Includes additional allowance for dependents.
[5] Figures not available to National Council on Compensation Insurance for monopolistic State fund. Source: Production workers in manufacturing, 1960 statistical supplement, Monthly Labor Review, pp. 33-35 (U.S. Department of Labor).
[6] Figures not available, varies in each State.

Senator DOUGLAS. Mr. Chairman, may we ask the Bureau of Labor Statistics to furnish this tabulation as close to the present date as possible?

Senator LONG. I will ask the staff to see if they can get that.

(The following was later received for the record:)

Ratio of maximum weekly benefit for temporary total disability to average weekly wages, by State

State	Maximum weekly temporary total disability benefit for single worker or for worker with dependents where law makes no provision for dependency allowances, 1963	Maximum weekly temporary total disability benefit for worker, wife, and two dependent children where additional compensation is allowed for dependents, 1963	Average weekly wage as reported under the State unemployment insurance acts, 1962	Ratio of maximum temporary total disability benefit for worker, wife, and two dependent children to average weekly wage [1] (Percent)
Alabama	$38.00		$80.99	46.9
Alaska	100.00		150.98	66.2
Arizona	150.00	$156.90	100.74	155.7
Arkansas	35.00		68.94	50.8
California	70.00		113.29	61.8
Colorado	43.75		96.80	45.1
Connecticut	55.00		104.82	52.5
Delaware	50.00		109.49	45.7
District of Columbia	70.00		99.16	70.6
Florida	42.00		85.50	49.1
Georgia	37.00		79.13	46.8
Hawaii	75.00		86.57	86.6
Idaho	32.00	45.00	85.88	52.4
Illinois	51.00	55.00	109.24	50.3
Indiana	42.00		103.41	40.6
Iowa	34.00	42.00	90.65	46.3
Kansas	42.00		92.10	45.6
Kentucky	38.00		87.04	43.7
Louisiana	35.00		88.75	39.4
Maine	42.00		80.64	52.1
Maryland	48.00		91.05	52.7
Massachusetts	53.00	71.00	93.87	75.6
Michigan	83.00	45.00	116.95	38.8
Minnesota	45.00		96.83	46.5
Mississippi	35.00		69.94	50.0
Missouri	47.50		96.69	49.1
Montana	29.00	40.00	89.97	44.5
Nebraska	40.00		88.09	45.4
Nevada	45.00	62.31	113.56	54.9
New Hampshire	45.00		82.79	54.3
New Jersey	45.00		108.09	41.6
New Mexico	38.00		92.36	41.1
New York	55.00		108.99	50.5
North Carolina	37.50		74.26	50.5
North Dakota	45.00	51.00	85.81	59.4
Ohio	56.00		107.35	52.2
Oklahoma	37.50		89.77	41.8
Oregon	32.31	50.77	97.27	52.2
Pennsylvania	47.50		95.59	49.7
Puerto Rico	35.00		46.61	75.1
Rhode Island	45.00		85.07	52.8
South Carolina	35.00		72.39	48.3
South Dakota	38.00		87.12	43.6
Tennessee	36.00		81.04	44.4
Texas	35.00		90.05	38.9
Utah	40.00	48.55	92.67	52.4
Vermont	39.00	44.00	83.51	52.7
Virginia	37.00		81.95	45.1
Washington	38.06	57.69	106.13	54.4
West Virginia	38.00		97.10	39.1
Wisconsin	64.00		100.19	63.9
Wyoming	40.38	55.38	88.44	62.6

[1] The percentages in this column are found by dividing the maximum weekly benefit for a worker, his wife, and two dependent children by the average weekly wage. The 1963 benefit is divided by the 1962 average weekly wage, as the wage data for 1963 were not available when the ratios were computed.

Mr. KALMYKOW. A good many of the figures we have mentioned are attached to the statement we have submitted. A lot of those figures are in here.

Senator DOUGLAS. I want to congratulate you on having as your counsel former Senator Keating. We miss him and you are brilliantly represented by him.

Mr. DORSETT. We think so, too, Senator Douglas.

Mr. KEATING. Thank you very much.

Senator LONG. Senator Curtis?

Senator CURTIS. Mr. Chairman, I want to say we are glad you are here and we have a special greeting to Senator Keating.

Isn't it true that this section 303 does not need to be necessarily a part of this bill dealing with hospital and medical care; isn't that correct?

Mr. KALMYKOW. Yes; it has no integral part in that scheme.

Senator CURTIS. While I am not in favor of this bill, I am anxious to see to it if the Congress is to pass a bill that it be as good a bill as possible. It is a giganticundertaking. The amount of money that will come in under it, the number of people to receive benefits, to start immediately will be a very sizable undertaking.

Therefore, I think the Congress should do the best job of legislating it can, and it seems to me that this section 303 without determining its merits necessarily, it will be well to delete it and take it up at a later time as a separate item rather than to give it limited attention now in the many complex provisions of its program.

Would you agree with that?

Mr. KALMYKOW. I certainly do.

I think, as I indicated before, it is such a departure from the present concepts of what the Social Security Act is intended to cover that I think it might be well to give the matter considerable study before taking such an important step.

Senator CURTIS. That is all, Mr. Chairman.

Senator DOUGLAS. Mr. Chairman, if I may ask, but wouldn't that leave this overlap existing in cases of permanent total disability?

Mr. KALMYKOW. Yes, it would. At least it would extend it——

Senator DOUGLAS. You are ready to do that?

Mr. KALMYKOW. Well, as we indicated before, we would prefer to see the offset restored, but if there is a desire for further study in this area, we certainly would like to see no extension of that principle.

Senator LONG. Thank you very much, sir.

Dr. DORSETT. Thank you.

Senator LONG. In compliance with a previous request of the Committee the Department of Health, Education, and Welfare has submitted a memorandum on the operation of the "pass on" provision. I believe it would be helpful to insert that memorandum in the record today since the subject has been discussed.

(The memorandum referred to follows:)

OPERATION OF "PASS ON" PROVISION

The "maintenance of State effort" or "pass on" provision contained in title IV of H.R. 6675 is basically intended to assure that States do not receive additional Federal funds under the bill while at the same time reducing their expenditure of State or local funds. The new formulas for Federal participation in assistance payments, the expended medical care program, and the elimination of restrictions on aged mental and tuberculosis patients makes available approximately $425 million a year in additional Federal funds on the basis of existing State and local expenditure. In addition, about $600 million a year of hospital care and other medical services for public assistance recipients would be met through the social insurance system, rather than through Federal-State public assistance payments.

The pass on provision works this way. Assume that a State's total expenditure for public assistance have been $100 million—$50 million of Federal funds and $50 million of State funds. Under the bill, the new formulas might entitled this State to $60 million in Federal funds on the basis of its $50 million of State fund expenditure if these were exactly maintained; this would be an increase of $10 million in Federal funds. If the State's total expenditures rose

to $110 million—an increase of $10 million—the State would be entitled to the full $60 million from the Federal Government since it was maintaining its $50 million.

If the State's total expenditures only rose $5 million—to $105 million—then the State would receive $55 million in Federal funds even though the new matching basis might have entitled the State to $58 million of Federal funds, since the "pass on" provision requires that the increase in Federal funds cannot be more than the increase in total expenditures—$5 million. In any event, to receive more from the Federal Government than the $50 million previously received, the State would have to fully maintain its $50 million State fund expenditure.

Assume that a State had been spending $11 million, divided equally between Federal and State funds and that it continued to spend this amount in the future. Even though the new matching formulas might indicate a larger Federal share than 50 percent (or $50 million), this would not result because the State would still have to put up the $50 million that it had previously. In other words, there can be no increase in Federal funds if there is no increase in total expenditures, and likewise the increase in Federal funds cannot exceed the increase in total expenditure.

Assume that another State had been spending $100 million, divided equally between Federal and State funds. In this State, however, because of the availability of the new hospital insurance program, the increase of OASDI benefits, et cetera, both the total expenditure and the Federal and State expenditures all dropped, instead of increasing. The total dropped from $100 to $90 million, and then under the new matching formulas the State's share decreased from $50 million to $43 million and the Federal share decreased from $50 million to $47 million. In this instance, although the proportion of the Federal funds would be higher than under present law, there would be no adjustment made under the "pass on" provision since the Federal participation would be lower in dollars than for the earlier period.

Senator LONG. The next witness will be Mr. James A. Flynn, New York Shipping Association.

STATEMENT OF JAMES A. FLYNN, COUNSEL, NEW YORK SHIPPING ASSOCIATION, INC.

Mr. FLYNN. Mr. Chairman and members of the committee, my name is James A. Flynn. I am with the firm of Lorenz, Finn & Giardino as counsel to the New York Shipping Association.

My remarks will also be addressed to section 303 of H.R. 6675, and in many respects will parallel those that Mr. Dorsett who preceded me stated.

We are concerned that if section 303 is enacted into law, it will result in further extension of the area of duplication of benefits which has been subject to question just a few minutes ago.

In the time allotted, I would like to summarize the reasons set forth at greater length in my written statement why our New York Shipping Association opposes section 303 in its present form. It is our view that this very important and very drastic increase or change in Social Security Act was unwisely inserted into the medicare program. We feel it is a subject properly of a separate bill. It was inserted without advance notice or hearings of any kind, and without an opportunity for those who were vitally interested in the problem to be heard, as the Senate has given us the opportunity to be heard now.

We think that if enacted it will seriously endanger the effectiveness of State and Federal workmen's compensation laws which have been successfully developed over the past 50 years.

Briefly, the present law provides for a disability payment if a person is totally disabled, totally and permanently disabled, or else the disability is of indefinite duration.

Section 303 would drastically change that by providing for disability payments if the total disability lasted for 6 months or longer. This is a drastic and significant change.

We have reviewed our own records to see the extent of the duplication of benefits that will result and we have selected two cases and these were selected at random to show how this area of duplication would be enacted.

In the first case, and this is an actual case, the employee earned approximately $6,000 the 21 months preceding his disability. Under New York compensation law which is about to be increased to $60 per week he would receive approximately $3,120 a year.

If section 303 is enacted, he will also receive a disability benefit under the Social Security Act of $3,380 for a total benefit after the first 6 months of over $6,000.

Now, on a $6,000 salary a man will pay approximately $700 or $800 in taxes—Federal, State, and social security. Under our example, this individual would receive approximately a thousand dollars a year in disability benefits from both State and Federal in excess of his net take-home wages prior to disability.

In the second case the example is even more sharply drawn because the employee is subject to the Longshoremen's and Harbor Workers' Compensation Act which has a weekly benefit rate of $70, maximum weekly benefit rate of $70.

In this case the duplication of benefits would result in the employee receiving approximately $1,700 more in a 12-month period than his net after tax take-home wages.

In its report to the House the House committee expresed its awareness of this problem and it sought to meet this problem by calling for study by the Social Security Administration.

We respectfully submit that this approach of legislating first and then looking afterward is wrong. We think that the Social Security Administration could very quickly make a study and come up with a fairly accurate estimate as to the amount of duplication.

All of the States' workmen's compensation laws are administered by State agencies which keep records of cases and the disability rates and the length of disability. We think in the matter of a few months the Social Security Administration could determine within a few thousand dollars the exact extent of duplicate payments under both laws that would occur. We believe that this should be done before section 303 is enacted and not afterward.

Some of the reasons why we are opposed to section 303 in its present form:

For one thing it would be very expensive. Using the House committee's own estimates, the House committee estimated if section 303 were enacted approximately 155,000 persons would become immediately eligible for benefits. If each of these persons received only $200 a month benefit, which is a conservative figure under the new schedules, this would amount to about $372 million a year the first year. I think this is a considerable sum. I think when you are deal-

ing with figures this high that the Congress should carefully consider providing for at least an offset to workmen's compensation payments.

Another reason why we are concerned is one touched on lightly by Mr. Dorsett and that is under workmen's compensation each employer is taxed to pay for the industrial accidents and this is always according to his experience. This provides a valuable incentive for employers to take steps to reduce the number of disabling accidents in his employment. Many employers have spent a great deal of time and money installing safety devices and conducting safety programs, all for the purpose of minimizing or eliminating the possibility of disabling injuries.

We think this incentive would be largely removed if the social security disability benefits were duplicated by the States' workmen's compensation laws.

Lastly and perhaps of the greatest importance, we are concerned about the broad expansion of the Federal Government in this area. This is not a situation in which States have been remiss in their responsibilities as in some other cases. All States have workmen's compensation laws, and all have been modified extensively during the years as the time has shown a need for change.

To duplicate the benefits now provided by State workmen's compensation laws as section 303 proposes to do would have but one effect, we think, on these very carefully considered and developed programs. We think the States would themselves provide an offset for social security benefit payments. Thus the burden and administration of providing workmen's compensation benefits in this country would significantly shift from the States to the Federal Government.

In a recent speech at the 50th anniversary symposium of the New York State workmen's compensation law, S. E. Senior, the highly respected chairman of the State board summarized this concern as follows: He said:

> It must be conceded that expansion of the Federal disability insurance program poses a serious threat to the continued existence of State workmen's compensation systems.

Mr. Senior also pointed out that—

> no American State contributes from public funds to the payment of workmen's compensation benefits. The system is entirely supported by employer contributions; in some States, including New York even the actual cost to the State of administering the Compensation Act is borne not by the public but by private funds.

For these reasons, we respectfully urge the committee to take a serious look at this act and to at the minimum give it a very careful consideration before passing it into law.

Thank you very much.

(The prepared statement of Mr. Flynn follows:)

STATEMENT OF NEW YORK SHIPPING ASSOCIATION, INC.

Mr. Chairman, members of the committee, my name is James A. Flynn. I am with the firm of Lorens, Finn & Giardino of New York City, counsel to the New York Shipping Association, Inc.

New York Shipping Association is composed of some 145 members, including American and foreign steamship lines, steamship agents, contracting stevedores and other maritime employers operating in the port of Greater New York.

My remarks will be addressed solely to section 303 of H.R. 6675. This section, under the guise of being a relatively minor item in the total medicare package, would effect fundamental and far-reaching changes in the social security disability insurance program. If enacted into law, this section will result in the further extension of the area of overlapping and duplication of disability insurance benefits under the social security program with those now provided by the workmen's compensation laws of the States and the Federal Government.

It is the New York Shipping Association's view that section 303 was unwisely inserted into the medicare bill without adequate study of the problems involved, without advance notice, and without an opportunity for those vitally interested in this problem to be heard. If enacted it will seriously endanger the effectiveness of State and Federal workmen's compensation laws which have been successfully developed over the past 50 years.

Section 303 consists of but a few pages of the 294-page medicare bill as passed by the House of Representatives. As described by the House committee, the effect of section 303 is to "broaden the area of protection" afforded by the social security disability program. In order to appreciate fully what the committee meant by this statement, the following brief history of the disability insurance program under social security is of interest.

The Social Security Act now provides for disability benefits in the event of an impairment "which can be expected to result in death or be of long, continued and indefinite duration" (present sec. 216(i)(1) and sec. 223(c)(2)). When originally enacted into law in 1956 these benefits were limited to persons 50 years or older and were offset by any benefits received under workmen's compensation laws. In less than 5 years' time, subsequent amendments eliminated both the offset of workmen's compensation payments and the age 50 requirement, and extended benefits to wives and children of the disabled employee.

Now in yet another giant step, section 303 proposes to redefine disability under the Social Security Act "to mean a continuous period during which an individual was under a disability, if such period is of not less than 6 full calendar months duration." Under this change any insured individual of any age now receiving workmen's compensation benefits for a temporary total disability of 6 months' duration or more would also receive substantial disability benefits under the social security program. Although benefits from each source are each specifically designed to meet the disabled employee's needs, and thus are based on a percentage of his gross wages prior to the disability, the aggregate of benefits from each source, if section 303 is enacted, could far exceed in many cases the worker's net take-home wages prior to the disability.

Some actual cases taken from the files of the New York Shipping Association show the extent of duplication that could result if section 303 is enacted into law as now written;

In the first case, the employee earned approximately $6,000 in the 12-month period prior to his disability. As a married man without children he would have an after-tax, take-home pay of about $5,200. As a result of an employment injury he has been totally disabled for the past 18 months. Under New York's workmen's compensation law, which is about to have its maximum weekly benefit rate increased to $60, this employee would receive at the new rate, if his disability continued, a total of $3,120 in disability payments during each 12-month period. If section 303 becomes law, he would also receive social security disability benefits of about $3,080 during each 12-month period following the initial 6-month waiting period under the Federal act. The total of his State compensation and social security benefits would amount to about $6,200 over each 12-month period of his disability, or some $1,000 over his net after-tax wages prior to the disability.

The second case involves an employee subject to the Federal Longshoremen's and Harbor Workers' Compensation Act, which has a maximum weekly benefit rate of $70. The employee earned approximately $5,800 in the 12 months prior to his disability. He is married with no other dependents and would have an after-tax take-home wage of about $5,000. He was injured in April of 1964 and has been totally disabled ever since, but is expected to return to work. Under the Longshoremen's Act he will receive a total of $3,640 per year during his disability. If section 303 is enacted, he will also be entitled to receive about $3,080 annually in social security disability benefits after the 6-month waiting

period, for a total from each source of $6,720 or some $1,700 in excess of his net take-home pay.

In its report, the House committee showed its awareness of this concern over the payment of duplicate benefits and sought to meet the understandable objections that would be raised by calling for a study by the Social Security Administration of the significance of overlapping benefits under the two programs. A report is to be made to the committee by December 31, 1966. This study is to include recommendations as to whether any action should be taken under the Federal disability program or under the State workmen's compensation program "to control excessive payments in cases of entitlement, as well as the effect of costs to employers" (report, p. 90).

We respectfully submit that this procedure of "legislating now and looking later" is unwise and unnecessary. A more practical and far less expensive approach is to require the Social Security Administration, before section 303 is enacted into law, to obtain information from the various State agencies administering workmen's compensation laws as to the number of cases of total disability in each State that exceeded 6 months' duration. This information should be readily available and would permit a determination not only of the number of cases where dual benefits would occur, but the amount of such benefits and, therefore, the extent of overlapping that would take place as between both programs. We believe this is a far more judicious approach than to leap into the unknown which H.R. 6675 proposes to do with its serious potential for harming existing workmen's compensation systems.

Why is the New York Shipping Association and so many others opposed to section 303 in its present form?

In the first place, section 303 will prove to be enormously expensive. Using the House committee's own estimates as to the number of employees that will be immediately eligible for coverage under this program, it is reasonable to foresee section 303 costing the social security program about one-half billion dollars per year. This cost will be added on top of the great additional costs that will result from passage of the basic medicare program. At a minimum, a large portion of this cost can be saved taxpayers if section 303 is amended to provide for an offset for workmen's compensation benefits.

Second, the benefits developed under workmen's compensation laws of the States were designed to meet the needs of the disabled employee—that is, providing him with income during a period when he is unable to work. The amounts of these weekly benefits, payable under both State and Federal laws, are set at a level to provide a reasonable income in relation to his predisability earnings, taking into consideration the fact that such benefits are not subject to Federal or State income taxes. Also, in the case of New York at least, when the cost of living has required an increase in the maximum weekly benefit the State legislature has promptly responded. In fact, the New York Legislature is expected to increase the maximum weekly benefit rate at this session.

This approach, which is carefully tailored to meet the needs of the disabled worker would be thrown all out of kilter if section 303 is enacted. As we have shown, many employees would receive what would amount to windfall payments by the duplication of benefits from each program, and the needed incentive to return to gainful employment upon termination of the disability would be largely removed. Since disability benefits under the social security program would not begin util the end of the first 6 months of the disability, we predict that the length of temporary total disability compensation cases will significantly increase.

Third, under workmen's compensation systems each employer is taxed to pay for industrial accidents and disabilities according to his experience. This provides a valuable incentive to employers to take steps to reduce the number of disabling accidents in their employment. Many employers have spent a great deal of time and money installing safety devices and conducting safety programs, all for the purpose of minimizing or eliminating the possibility of disabling injuries.

However, the cost of benefits under section 303 would be borne by the social security program and employers that took vigorous steps to reduce accidents would be taxed at the same rate as employers without safety programs or who engaged in more hazardous employment. Thus, section 303 would destroy the

direct relationship which exists under workmen's compensation laws between accidents, costs, and insurance premiums.

Finally, and perhaps of greatest importance, section 303 represents a broad expansion of the Federal Government into an area that for many years has been adequately handled by the States. This is not a situation where the States have been remiss in their responsibilities. All States have workmen's compensation laws and these laws have been the subject of continuing change as experience has shown the need for modification. To duplicate these State benefits—as section 303 proposes to do—would have but one effect on these carefully developed programs. It would encourage States to remove the possibility of duplication of benefits by providing that such benefits be offset by the amount of benefits received under the social security program. Thus, the burden and administration of providing workmen's compensation benefits in this country would significantly shift from the States to the Federal Government.

In a recent speech at the 50th anniversary symposium of the New York State workmen's compensation law, S. E. Senior, the highly respected chairman of the New York State Workmen's Compensation Board, summarized this concern over section 303. He said:

"It must be conceded that expansion of the Federal disability insurance program poses a serious threat to the continued existence of State workmen's compensation systems."

The chairman later expanded on this as follows:

"In a world which contains so many socialist and welfare states, there seems to be a complete lack of appreciation of the solid free enterprise foundationstone upon which the workmen's compensation system was built. No American State contributes from public funds to the payment of workmen's compensation benefits. The system is entirely supported by employer contributions; in some States, including New York, even the actual cost to the State of administering the Compensation Act is borne not by the public, but by private funds."

For all of these reasons we respectfully urge the committee to take a long hard look at this very costly duplication of disability benefits that will result if section 303 becomes law. We are convinced that in its present form section 303 will seriously undermine existing workmen's compensation programs.

Senator LONG. Any questions?

Senator DOUGLAS. No questions.

Senator CURTIS. No questions.

Mr. FLYNN. Thank you very much.

Senator LONG. Thank you, sir.

The next witness will be Dr. Ira Leo Schamberg, Committee on Social Security for Physicians.

STATEMENT OF DR. IRA LEO SCHAMBERG, CHAIRMAN, COMMITTEE ON SOCIAL SECURITY FOR PHYSICIANS

Dr. SCHAMBERG. Mr. Chairman, Mr. Curtis, Mr. Douglas, Mr. Hartke, my name is Ira Leo Schamberg. I am a physician, a dermatologist, in private practice in Elkins Park, Pa. I am assistant professor of dermatology in the School of Medicine and the Graduate School of Medicine of the University of Pennsylvania. I am a special consultant to the U.S. Public Health Service. I am chief of dermatology at the Albert Einstein Medical Center as well as at a number of other hospitals. As a member of the Philadelphia County Medical Society, I have in the past served on the legislative and venereal disease committees of this society. In addition, I was elected to serve as a delegate from the Philadelphia County Medical Society in the Pennsylvania State Medical Society and served in this capacity from 1961 to 1963.

As chairman of the Committee on Social Security for Physicians, which is supported by and represents the point of view of many thousands of physicians throughout the country, I respectfully urge the Senate Finance Committee to leave intact the provisions for social security coverage of self-employed physicians which was passed by the House of Representatives in accord with the recommendation of the House Ways and Means Committee.

I urge further that physician coverage be made retroactive by covering self-employed physicians for taxable years which begin during the year of enactment of the pending legislation; and by covering interns effective the first calendar quarter subsequent to the enactment.

I am encouraged to believe that the evidence which persuaded the House Ways and Means Committee and the House of Representatives, both Democrats and Republicans, to vote so overwhelmingly in favor of extending social security to self-employed physicians, will likewise convince this committee of the justice and wisdom of this legislation. When I testified before this committee in August 1964, I based my statement on the amply demonstrated facts that doctors of medicine both need and want social security coverage. The evidence for our need of such insurance will be presented by Mrs. Gertrude Rost, the wife of a physician.

Evidence for the fact that we physicians want social security protection has been demonstrated over and over again by many statewide polls the results of which have been taken and are set forth in the accompanying table, which is with the mimeographed copy of my statement.

You will observe that 62.5 percent of all the physicians voting are in favor of social security coverage. In 1963 as a delegate to my State medical society house of delegates instructing our society to accept the mandate of our poll, our State poll, and to present and support at the next meeting of the House of Delegates of the American Medical Association a resolution favoring social security for physicians.

The house rejected my resolution demonstrating again that the voice of the grassroots is not heard in the meeting halls of the delegates. These proceedings are documented in a letter I have here from a physician's wife, which I will be happy to submit to the committee.

It is crystal clear that the American Medical Association does not represent the desires of American physicians on this issue; and cannot claim to represent its members since the association has never taken a national poll on this question as did the American Dental Asssociation and the American Bar Association, which before their members were admitted to social security did take such national polls.

Inclusion of self-employed physicians is strongly recommended in the 1965 Report to the President of the Advisory Council on Social Security—copy of the significant section attached. This report states:

> Self-employed doctors of medicine should be covered on the same basis as other self-employed people now covered.

The Council states that it sees no reason why self-employed physicians should be discriminated against as the only professional group not covered by social security. It is further pointed out by the Coun-

cil that social security is not only a mechanism in which a person participates because of the benefits he as an individual expects to receive, but it is an institution through which all Americans together promote economic security by financing from the contributions of all a continuing income to families whose earning are cut off by old age, death, or disablement of the worker.

Like all other Americans, we self-employ physicians benefit in decreased taxes for welfare purposes because of the social security system—but without contributing so much as a dime. Also, the Advisory Council on Social Security shows how we have an additional unfair advantage over other Americans in that we need only work in a part-time salaried position for a few years in order to qualify for retirement benefits. Many older physicians, anticipating retirement, do exactly this so that they may receive the benefit of a monthly social security check. Since such part-time salaried employment usually represents only a very small fraction of the income of the practicing physician, we obtain the advantage of the weighted benefit formula designed not for us but the truly low-income group. A physician who qualifies for social security as a result of a few years of salaried work thus gets a disproportionate and unfairly large return in relation to the contribution he makes to the social security system.

Less than a month ago the policy planners of the U.S. Chamber of Commerce refused to accede to the American Medical Association that it oppose physician coverage. Dr. DuPuy presented the point of view of the American Medical Association and he was answered by Mr. Marshall, former chairman of the chamber's security committee. Mr. Marshall argued that social security is not a private insurance plan but a combined tax system and benefit program. This is a social insurance scheme to protect society as a whole from mass poverty and indigency in old age, he pointed out.

Finally then, I ask this committee to consider objectively the evidence that we physicians need and want to be included under social security. I ask further that you recognize the validity of the statement made on this subject in the 1965 Report of the Advisory Council on Social Security, that until we are brought under the social security umbrella, we are freeloaders who are taking financial advantage of all of the other citizens of this country. Physicians should be included in the social security system and pay their share in fairness to all other American workers.

Thank you very much.

(The attachments referred to follow:)

Results of State medical society social security polls

State	In favor	Opposed	Number of votes in AMA House of Delegates
States for social security (19):			
California [1]	635	372	21
Connecticut	1,391	504	3
Delaware	135	85	1
District of Columbia	550	192	2
Florida	957	714	5
Maine	369	210	1
Massachusetts	3,253	988	6
Michigan	1,781	1,048	7
Missouri [2]	277	148	4
New Jersey	2,174	916	6
New York [3]			24
Ohio	4,095	2,737	9
Pennsylvania	5,605	3,335	11
Rhode Island	[4] 70	[4] 30	1
South Dakota	155	104	1
Utah	322	188	1
Vermont	[4] 65	[4] 35	1
Washington State	[4] 60	[4] 40	4
West Virginia	436	237	2
Total			[5] 110
States against social security (8):			
Arkansas	167	596	2
Georgia	406	589	3
Illinois	2,790	3,301	11
Indiana [2]	181	246	5
Minnesota	817	1,030	4
Oklahoma	446	761	2
Virginia	[4] 38	[4] 62	3
Wisconsin	854	870	4
Total			34

[1] A 1-in-10 poll by Honest Ballot Association.
[2] A 1-in-5 poll by Honest Ballot Association.
[3] Based on county society polls and State society resolutions.
[4] Percent.
[5] A clear majority of the 202 votes in the AMA House of Delegates.

NOTE.—The remaining State medical societies, which represent 58 votes in the AMA House of Delegates, have not held social security polls.

THE STATUS OF THE SOCIAL SECURITY PROGRAM AND RECOMMENDATIONS FOR ITS IMPROVEMENT

REPORT OF THE ADVISORY COUNCIL ON SOCIAL SECURITY, WASHINGTON, 1965

11. DOCTORS OF MEDICINE

Self-employed doctors of medicine should be covered on the same basis as other self-employed people now covered, and interns should be covered on the same basis as other employees working for the same employer

Self-employed physicians, numbering about 170,000, are the only professional group whose self-employment income is not covered under social security. The Council sees no reason why this discriminatory treatment should be continued. There are no technical or administrative barriers to the coverage of doctors. Nor is there any question that many doctors have a need for coverage as great as that of other professional self-employed people. A provision for covering self-employed doctors was approved by the House of Representatives in 1964.

Apparently physicians have been excluded up to now because spokesmen for the profession have indicated opposition to coverage. The Council believes that the wishes of a particular group are not a sufficient basis for the continued exclusion of the group. Social security is not only a mechanism in which a person participates because of the benefits he as an individual expects to receive. It is an institution through which all Americans together promote economic security by financing, from the contributions of all, a continuing income to families whose earnings are cut off by the old age, death, or disablement of the worker. Physicians, like all other Americans, benefit in general tax savings and in other ways from the prevention of dependency through social security. Like other Americans, they should share in its support. In fact, failure to cover the self-employment income of physicians has the effect that many of them have an unfair advantage under the program, since it is possible for them to acquire insured status through working for a time in covered employment, and then, because those who do so have low average monthly earnings under the program, they get the advantage of the weighted benefit formula that is intended for low-income people. Thus many of those who do qualify get a very large return in relation to the contributions they pay, in comparison with self-employed people who spend all of their working lifetimes in covered work.

The present exclusion from social security coverage of interns employed by hospitals is closely related to the exclusion of self-employed physicians. The Council believes that when self-employed physicians are covered, coverage should be extended to interns on the same basis as that on which coverage is now made available to other employees of hospitals.

Senator DOUGLAS. Doctor, I am much interested in the results of these polls that you give in the appendix to your testimony. Do you want to have those made a part of your testimony?

Dr. SCHAMBERG. Yes, indeed; I do.

Senator DOUGLAS. You say that these are the results of State medical society social security polls. Were these taken by the State medical societies?

Dr. SCHAMBERG. In most cases, Senator Douglas. In a few cases a poll was taken by the Honest Ballot Association which I understand is a very reputable organization with no bias, and there is one other exception and that is in New York State. Many county medical societies in New York State took individual resolutions, in some cases polls, and the vast majority of those resolutions and polls favored social security and for that reason we feel that even though we don't have numbers it is proper to place New York State in the category of the States whose physicians, the majority of whose physicians, wish social security.

Senator DOUGLAS. This is a very important point and I would like to go into the question of these polls in some detail.

I notice that in California you say this was a poll by the Honest Ballot Association, taking 1 name out of every 10, is that true? In other words, it was a sampling poll?

Dr. SCHAMBERG. Yes, sir.

Senator DOUGLAS. And that seems to be indicated by the fact that the total number of votes was about 1,100, and in a State of 17 million, you would normally expect to have somewhere around 15,000 to 17,000 physicians. And similarly in Missouri this is stated to be a 1 in 5 poll by the Honest Ballot Association.

Do I understand that all the other polls are pollls taken by State societies?

Dr. SCHAMBERG. You understand correctly, Senator Douglas.

Senator DOUGLAS. No, have you tabulated the total votes in favor as opposed to the total votes opposed in all the States?

Dr. SCHAMBERG. I believe, but I cannot be certain at this moment, that the total votes in favor constitutes 62½ percent of all those voting in these State polls.

Senator DOUGLAS. Now, on these State society polls, have you examined the procedure in detail there?

Dr. SCHAMBERG. Frankly, only in my own State. Our State medical society in Pennsylvania held two polls, and in each of those a post card was mailed to every member of the State society on which he was asked to indicate his feelings.

Senator DOUGLAS. Was that a secret ballot or do the doctors who voted sign their names?

Dr. SCHAMBERG. I should know the answer to that but that was several years ago.

Senator DOUGLAS. There is a very important question.

Dr. SCHAMBERG. I think I may have some answer here. This is a letter from the David M. Small, the administrative assistant of the Pennsylvania Medical Society, this is a letter dated April 28 of this year to the wife of an New Jersey physician in replying to her letter requesting information. He says:

The last poll of the membership on this issue was conducted in 1961 at the direction of our house of delegates. Cards were mailed to the then 10,350 active members of the society, and a total of 8,636 physicians replied.

I, of course, received one of these post cards. I honestly cannot recall whether I signed my name.

Senator DOUGLAS. Well, my memory is imperfect on this but, as I remember, the poll of the Illinois society was one in which the physicians identified themselves.

Dr. SCHAMBERG. I might say——

Senator DOUGLAS. Is a representative of the Illinois society here? Does anyone wish to speak to that?

Mrs. ROST. I think in Illinois, if I am informed correctly, the cards were numbered or something so if the State society wanted to identify the physicians they can do it. But they did not have to sign their names. In most cases it was an anonymous poll.

In New Jersey, for instance, I know that it was. But I think in Illinois the cards that were sent out could be identified if one wanted to by some means.

Senator DOUGLAS. That is my memory, and if my memory serves me also there had been a previous poll by the Honest Ballot Association which instead of showing a majority against showed a majority in favor of coverage.

Mrs. ROST. This was taken before the Illinois State Society poll and shows the spontaneous reaction of the physicians.

Senator DOUGLAS. I am going to ask that a copy of what purports to be a certification by the Honest Ballot Association dated May 23, 1960, be included in the record at this point, and I would like to read the salient passages here. It is signed by George J. Abrams, executive secretary, Committee on Labor Elections of the Honest Ballot Association.

I hereby certify that 11,942 ballots were mailed as certified to us by the U.S. Post Office Department and, of these, 5,967 ballots were returned untabulated.

I further certify that the following is true and accurate count as taken from the 5,967 ballots as to the outcome of the vote.

The question, Should physicians be included in the Federal social security program? Yes, 3,964. No, 1,962. Blank, 41.

I further certify that of those voting a majority requested that physicians be included in the Federal social security program,

indicating approximately a 2 to 1 vote.

Whereas the poll by the State medical society shows 3,301 opposed and 2,780 for, a vote of about 5 to 4 against.

When this issue was before the committe last year, I only knew of the poll by the State medical society and I then voted in committee against the inclusion of physicians. Later the poll by the Honest Ballot Association, which had not been introduced as evidence, came to my attention, and as a result, although there was not a rollcall, I voted for the inclusion on the floor of the Senate.

Now, do you say, therefore, that over 60 percent of the physicians polled in these various studies have voted for inclusion under social security?

Dr. SCHAMBERG. Voted for compulsory inclusion.

Senator DOUGLAS. Compulsory inclusion?

Dr. SCHAMBERG. Might I say, Senator Douglas, that the Pennsylvania State Medical Society and its house of delegates has been uniformly, throughout the years, very violently opposed to coverage of physicians under social security?

Senator DOUGLAS. And yet you say——

Dr. SCHAMBERG. I am referring to your question as to whether or not we signed the postcard ballots. I would say knowing the State society was so opposed, if any man were concerned at idenifying himself as being not in concert with the State society he would be afraid to sign that he favored, and would not be afraid to sign that he did not favor social security for physicians.

Senator DOUGLAS. This is the point I am trying to establish. It is well known that the hierarchy in the American Medical Association and in most of the State associations is opposed to compulsory inclusion under Federal social security, and the question which I want to raise is whether there were identifying marks on the polls taken by the State associations which might make individual doctors fearful of voting for inclusion.

Can you furnish for the record copies of the ballot taken in Pennsylvania and make a summary of the form of the poll in other States? I think in all fairness copies of the statement I am requesting should be made available to the American Medical Association so that they may make any reply which they deem proper.

Dr. SCHAMBERG. I have here a copy of the latest poll taken in the State of Pennsylvania, but as I understand it you would like——

Senator DOUGLAS. This is April 28, 1965.

Now, this seems to be a poll from the Pennsylvania Medical Society. The results differ somewhat from yours. What is the distinction between covered and noncovered?

Dr. SCHAMBERG. Many physicians who have part-time employment, salaried employment are covered by social security.

Senator DOUGLAS. I see.

Then this report, under date of April 28, 1965, only a few days ago, signed by David H. Small, administrative assistant, Pennsylvania Medical Society, states that there were in favor 4,729, opposed 3,730,

or 55 percent in favor, 43 percent against, 1.7 percent, no opinion. Your results seem to show 5,605 in favor, 3,335 against. And I am going to ask that this letter, which purports to be from the Pennsylvania Medical Society, be included in the record.

I think this is very significant testimony because it comes from the association which is officially, I take it, opposed, yet it reports a poll of its members in favor.

(The letter referred to follows:)

PENNSYLVANIA MEDICAL SOCIETY,
Harrisburg, Pa., April 28, 1965.

Mrs. ERNA M. LAVES,
102 Connett Place, South Orange, N.J.

DEAR MRS. LAVES: Since I work closely with our policymaking bodies within whose primary area your question falls, Mr. Perry has asked me to answer your recent inquiry concerning our position on the inclusion of self-employed physicians under social security. You've also asked for the results of the poll of the membership which was conducted on this question.

The last poll of the membership on this issue was conducted in 1961 at the direction of our house of delegates. Cards were mailed to the then 10,350 active members of the society, and a total of 8,636 physicians replied. Of these replies, 39 could not be classified because of incomplete answers. The results of the poll were as follows:

Present status	In favor	Opposed	No opinion	Total
Covered	1,407	1,255	99	2,761
Not covered	3,271	2,428	49	5,748
Not indicated	51	37	0	88
Total	4,729	3,720	148	8,597
Percentage	55.1	43.2	1.7	100.1

In 1963, the House of Delegates considered the following resolution:

"*Resolved*, That the House of Delegates of the Pennsylvania Medical Society instruct the delegates from the Pennsylvania Medical Society to the House of Delegates of the American Medical Association to present and support at the next meeting of the House of Delegates of the American Medical Association a resolution favoring compulsory social security for physicians."

The house voted to reject this amendment.

Sincerely,

DAVID H. SMALL,
Administrative Assistant.

Senator DOUGLAS. Do you have any more evidence on this point? (See pp. 962, 963.)

Dr. SCHAMBERG. I feel that there is absolutely no question, based both on State polls, based on a recent 1965 poll carried out by a medical magazine known as Medical Economics.

Senator DOUGLAS. You never mentioned that before, the poll by Medical Economics. That was not included in your body of your testimony. I would like to hear about that.

Dr. SCHAMBERG. I would be very happy to submit this for the record. This is 1965. A sampling was requested by Medical Economics, saying, "Do you already have some social security coverage as a result of past or present employment? Yes, 53.5 percent. No, 38.3. Don't know, 8.2.

"If you already have some coverage, some social security coverage, how do you feel about it."

Of those who responded, 47.8 percent stated that they were glad to have it and wanted more; 33.5 percent said they were glad to have it but did not want any more. Adding those two figures 81.3 percent of the physicians who had some social security coverage were glad that they had it. The other two categories were "Would prefer not to have coverage," 16.7, and "Mixed feelings, 2 percent."

Senator DOUGLAS. What about those who were not covered, the independent practitioners?

Dr. SCHAMBERG. This is interestingly difficult. The question was asked, "If you do not already have some social security coverage do you want coverage for yourself?" 50.4 percent, just over a majority, said "Yes;" 28.6 percent said "No;" 11 percent were undecided.

Senator DOUGLAS. Would you have copies of that made and submitted for the record?

Dr. SCHAMBERG. I will be happy to submit this now.

Senator DOUGLAS. Very good.

Mr. Chairman, I request that this be made a part of the record.

(The information referred to follows:)

[Medical Economics, Mar. 8, 1965]

SOCIAL SECURITY NOW?

MOST SELF-EMPLOYED M.D.'S ALREADY HAVE SOME

"Do you already have some social security coverage as a result of past or present employment?"

	Percent
Yes	53.5
No	38.3
Don't know	8.2

"If you already have some coverage, how do you feel about it?

Glad to have it, want more	47.8
Glad to have it, don't want more	33.5
Would prefer not to have coverage	16.7
Mixed feelings	2.0

Source: MEDICAL ECONOMICS' survey of self-employed M.D.'s, 1965.

"I still feel that Congress may amend the Keogh Act to provide more favorable retirement benefits for self-employed doctors. Once we accept social security, that possibility is gone."

"We'll never get to use it. Most of the physicians in small towns will never get to use their social security (if they have it) because of the shortage of physicians and the unwillingness of most practitioners to quit working when their patients still need them."

"We conservatives are licked, so we might as well go along with socialism until the majority becomes intelligent enough to kick it out."

"With my family, social security would be worth $50,000 in insurance."

"It seems impractical, if not unjust, for the Government to exempt a special group from laws that apply to everyone else."

"An M.D. in his early 70's died recently. At one time he had been well-fixed financially, but he died broke, and our county medical society had to bury him. Social security would have been a Godsend for this man."

THE OUTS WANT IN—BUT JUST BARELY

"If you do not already have some social security coverage, do you want coverage for yourself?"

	Percent
Yes	50.4
No	38.6
Undecided	11.0

CONSENSUS: IT'S COMING, LIKE IT OR NOT

"Regardless of whether you favor or oppose social security coverage for all self-employed M.D.'s, do you believe they will be included in the social security program?"

	Percent
Yes	64.1
No	17.9
No opinion	18.0

Senator DOUGLAS. Do you know something about Medical Economics? How would you characterize it generally?

Dr. SCHAMBERG. Medical Economics is a journal which appears twice a month or every 2 weeks dealing with the medical coeconomic side of medicine. It, I feel, is a very honest magazine, it goes free to every practicing physician in the country.

Senator DOUGLAS. Free?

Dr. SCHAMBERG. Free.

Senator DOUGLAS. Who bears the cost?

Dr. SCHAMBERG. The costs are paid by the advertisers, and since the drug advertisers are more interested in advertising in a journal read by many physicians, Medical Economics, with its excellent staff proves of great interest to the majority of the physicians I know, and to myself.

Senator DOUGLAS. What board runs it?

Dr. SCHAMBERG. It is published in Oradel, N.J.

Senator DOUGLAS. Is it a private organization?

Dr. SCHAMBERG. I believe so.

Senator DOUGLAS. And if the income exceeds expenditure who gets the net profits?

Dr. SCHAMBERG. I certainly do not. And I don't know.

Senator DOUGLAS. I know you don't. But I mean do you know who does?

Dr. SCHAMBERG. I really do not know.

Senator DOUGLAS. Has it been regarded as a radical crusader for coverage of physicians under social security?

Dr. SCHAMBERG. Definitely not, Mr. Douglas. In fact, like the letters in pages in Time, they are equally accused of being to the right and to the left.

Medical Tribune is another tabloid type of newspaper sent at no charge to all physicians, and their nationwide poll, based on scientific sampling of possibly 2 years ago, agreed with the poll, with the two polls; the Medical Economics that most doctors of medicine want to be included under social security.

Senator DOUGLAS. Would you submit that for the record?

Dr. SCHAMBERG. I certainly will.

(The material submitted follows:)

(Telegram subsequently received from Committee on Social Security for Physicians, 510 Madison Avenue, New York, N.Y., giving the following information regarding the poll of Medical Tribune: Medical Tribune poll conducted July 24, 1961. This was a nationwide, scientific cross section including physicians from all areas of the United States. All major types of practice, urban, rural and suburban communities. Poll was anonymous; 57.7 percent voted yes with heavier banking by physicians over RP. Documentation follows.)

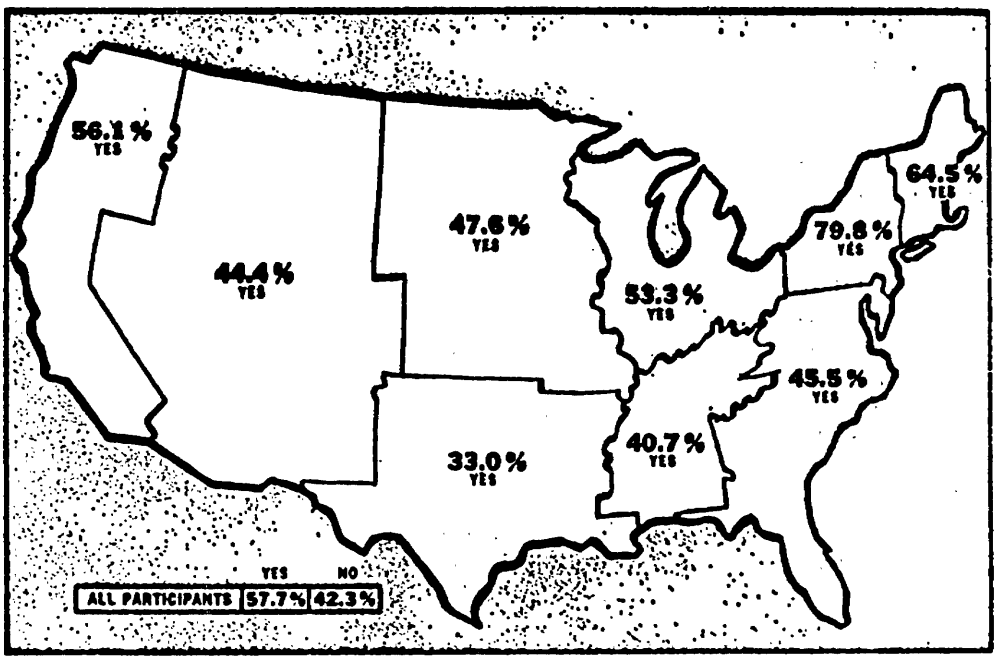
[From Medical Tribune, July 24, 1961]

TRIBUNE PULSE OF MEDICINE REPORT—57.7 PERCENT OF PHYSICIANS VOTE "YES" ON M.D. SOCIAL SECURITY COVERAGE

Social security coverage for self-employed physicans is favored by 57.7 percent of the 1,220 physicians who participated by responding to a Medical Tribune Pulse of Medicine poll on the issue. A total of 5,000 physicians in private practice received Pulse questionnaries to express their views. They represent a national cross section of Medical Tribune readers—physicians in all areas of the United States, in all major types of practice, and in urban and suburban as well as rural communities.

The poll was completed during the week that the American Medical Association's House of Delegates voted 147 to 29 against compulsory inclusion of physicians and rejected (in a separate vote) a resolution asking for a nationwide poll of physicians.

A summary of the poll's result according to age, community, and practice appears on page 24.



Heavier backing for social security coverage comes from physicians 40 and and over rather than those under 40, and from urban and suburban rather than rural M.D.'s.

Among specialty groups, only surgeons are opposed by a majority vote. Less than half want coverage, in contrast with more than 70 percent of dermatologists and psychiatrists.

Geographically, proponents are most numerous in the Northeast, least numerous in the South.

Offered a choice of statements about social security, many gave multiple answers but half agreed that all professional people should be covered; two-fifths, that retirement is an individual problem; two-fifths that social security is actuarially unsound.

About one-fifth think that social security for physicians would be a step toward socialized medicine; less than one-tenth, that the social security idea is good but not for physicians.

Information made available by medical organizations and journals was cited by just over half as a major influence in helping them reach their conclusions.

Patterns of Comment

"Do you favor extension of social security coverage to self-employed physicians?"

Nearly 58 percent do, and many agree with a District of Columbia GP: "In my opinion, there is no valid reason for exclusion of physicians." Others say, in the words of a Pennsylvania internist, that extension is "Long past due."

A Missouri GP wonders "how many M.D.'s say 'No' to this but hold on to salaried jobs to insure their inclusion."

One frequently repeated reason for approval is expressed by an Illinois surgeon: "That which applies to 90 percent plus of our country should apply to all." Closely allied is the view that "social security is here to stay—we might as well quit trying to be martyrs" (a Michigan psychiatrist).

Equally representative is the attitude of an Indiana GP: "We pay for it anyhow—why cut our own throats?"

Retirement benefits seem less important than other aspects of protection, in the opinion of a sizable group. For example, help in event of disability is mentioned by several, including this Alabama internist: "While the retirement benefits may be of questionable profit, there is little doubt that disability benefits are exceedingly worthwhile."

DEATH BENEFITS VALUED

Many others emphasize death benefits. A Maine specialist writes: "Retirement is not the problem of social security for physicians—it is the protection offered to the physician's family that is all-important * * * because of the early mortality of physicians," and an Illinois surgeon believes that "the death benefits provision alone, although only for a physician with a young family, more than makes the whole social security program advantageous."

Concern over older physicians is a recurrent theme. A Wisconsin GP says: "I know of many elderly physicians who are just barely existing, and if they had social security they could retire and not worry where the next nickel is coming from."

The issue of voluntary versus compulsory coverage was raised by more than 60 physicians. Four did not check either "Yes" or "No" but indicated they would favor coverage if voluntary. (A Colorado specialist writes: "I feel that social security should be made available to physicians—not compulsory.") Twelve checked "No," with remarks similar to this comment from an Arkansas specialist: "Not on a compulsory basis—only on a voluntary basis." Forty-five who checked "Yes" qualified their choice as did a West Virginia internist: "On a voluntary basis only."

TAX-DEDUCTIBLE SAVINGS

References to plans permitting tax-deductible savings for retirement were also frequent, and came from both proponents and opponents of social security coverage. A Michigan GP, for example, favors extension of coverage to physicians but adds: "However, Keogh bill is preferable," and many opponents agree with a Massachusetts specialist: "I favor tax deduction for a retirement fund."

Among the 42.3 percent opposed to social security coverage is the Michigan specialist who says, "Want to stand on my own feet till I die," and this stress on individual responsibility—plus dislike of Government action—characterizes a great segment of comments.

A Pennsylvania surgeon thinks "the less of earned or invested income handed to Federal Government, the better for the United States"; a Virginia GP believes "the Government does not owe everyone a living," and a Texas GP is convinced that "anything the Federal Government manages is wasteful and unprofitable."

PERSONAL RESPONSIBILITY

In the opinion of a New Jersey urologist, "Man reaches his highest degree of productivity and achievement by assumption of responsibility. When he passes on responsibility to government, he loses his self-respect, independence, ambition."

To many who do not favor extension of coverage to physicians, "social security as it is now administered is socialism" (an Iowa specialist). A Tennessee specialist is "opposed to all forms of socialism," and a Pennsylvania GP believes "physicians should continue to show their dislike toward America's drift toward a socialistic state even though they forgo a few dollars to be doled out from an unsound scheme."

The effect on coming generations is also given as a reason for opposition. "At my age," writes a California GP who is over 65, "younger people will have to carry the load," and he adds that the amount they will have to pay "will be all out of proportion to the benefits they will receive."

Some see support of social security for physicians as illogical: "Accepting it while fighting King-Anderson, McNamara, Kennedy, et al., would be paradoxical" (a California urologist).

"Which of the following statements do you agree with?"

"The social security idea is good, but not for physicians."

DO YOU FAVOR EXTENSION OF SOCIAL SECURITY COVERAGE TO SELF-EMPLOYED PHYSICIANS?

	Yes	No
All participants	57.7%	42.3%
M.D.s under 40	44.2%	55.8%
M.D.s 40-65	63.0%	37.0%
M.D.s over 65	64.0%	36.0%
G.P.s	54.7%	45.3%
urban	59.7%	40.3%
suburban	59.7%	40.3%
rural	40.8%	59.2%
internists	65.9%	34.1%
dermatologists	75.0%	25.0%
surgeons	48.6%	51.4%
ob-gyn	58.8%	41.2%
psychiatrists	71.9%	28.1%
pediatricians	53.6%	46.4%
radiologists	53.1%	46.9%

Although relatively few (7.3 percent) checked this statement, their chief objection is voiced by many others in comments: "Probably good if retire at age of 65, but because physicians tend to work beyond the age of 65, no benefit for physicians" (a Minnesota radiologist).

Restrictions on earnings of social security recipients are mentioned again and again by opponents as well as proponents of coverage. An Ohio surgeon favors extension to M.D.'s "but not if it means retirement to obtain it," and a Massachusetts specialist does not favor the plan because "at the age of 65 I shall not be able to retire on social security coverage. * * * The restrictions on earning money should be removed so that recipients of the coverage could continue to work as needed."

"Social security is actuarially unsound."

Two-fifths (41.3 percent) agree with this statement, including the Michigan internist who says, "The inventor of this basic idea was jailed for running a confidence game!" A South Carolina internist calls social security "a form of the old 'pyramid club' idea on a grandiose scale and sponsored by the Federal Government," and an Ohio internist sees it as the "old chain-letter gag."

One frequently voiced view: "It is a tax—not insurance. Why should younger physicians foot the bill for oldsters' retirement" (an Alabama GP).

An Illinois obstetrician believes social security "is in effect a tax-supported dole, the terms of which exist at the whim of the Congress. There is no contractual relationship, and the benefits paid are not necessarily in proportion to the 'premiums' paid in."

A counter argument in favor of social security comes from a California GP: "It may seem unethical that a man will collect social security after paying only 5 or 6 years while some pay all during their working years; however, in such vast projects such apparent injustices will be leveled off in time and are puny considering the immense numbers of people protected by the system."

"All professional people should be covered."

Close to half (47.6 percent) answered "Yes," some for the reason cited by a Pennsylvania GP: "Social security should be all-inclusive, regardless of employment, profession, or income; otherwise there should be no social security for any."

A New York GP asks, "Aren't dentists, lawyers, accountants, etc., professional people? Why has the American Medical Association not been fair about the entire matter? Most of the ruling groups in the national, State, county societies are covered by social security, yet they rule us out."

Many believe that professional people face financial problems in planning for retirement. "After taxes and with the high cost of living, what do you have left at the end of the year to save or invest?" writes an Iowa radiologist. A New York GP observes: "We are prone, such as others, to bad times, etc. I never will forget the bad times for us in the depression."

"Retirement is an individual problem."

Of the 41.8 percent who agree, a sizable number go along with an Oregon GP: "All physicians are perfectly capable of providing their own retirement, and I don't want anyone else paying for mine, nor do I want to pay for anyone else's."

Others disagree that the problem is an individual one. An Illinois surgeon says, "So is waiting for that ship to come in," and an Ohio surgeon adds after checking the statement: "But many unable to take care of own retirement."

"Social security for physicians would be a step toward socialized medicine."

About one-fifth (22.7 percent) checked this statement. Among the representative comments: "An indirect step toward socialized medicine in that it could be used as an argument for extension of the system" (a Pennsylvania psychiatrist).

A dissenting view comes from a Florida obstetrician: "On the contrary, I believe security is so important that more men will want salaried jobs—trend toward socialized medicine."

"In reaching your own conclusions about social security for physicians, which of the following factors have influenced you most?"

Dual choices were frequent, but half checked "information made available by medical organizations and journals"; 45.6 percent, "discussions with colleagues"; one-third, "reports in the lay press and magazines"; 12.5 percent, "statements by public officials."

Whatever the influence, it often brought sharply opposing views. After discussions with colleagues, for example, a Maryland GP favors coverage: "Although at first most physicians were against social security in principle, lately it seems as though there are more and more doctors in favor of inclusion in this program."

"A LAST STRONGHOLD"

By contrast, a Kentucky obstetrician has discussed the issue but opposes coverage: "We as a group represent one of the last strongholds against creeping socialism, of which social security is a part."

Similarly, an opponent from North Dakota writes: "Simple commonsense that even a Harvard economist should be able to understand points up the fallacies and inherent dangers," while a Virginia specialist cites "commonsense" as the factor that did most to influence his conclusion that coverage is desirable.

Both sides claim backing from insurance experts. ("Advice of an insurance agent," says an Iowa proponent of inclusion of physicians; "Explanation of financial facts regarding future payments of social security by insurance man," says a Michigan opponent.)

Many offer personal observations and reflections as reasons for their differing stands.

A Kansas specialist who does not favor coverage comments, "I have been raised to believe that the average person through diligence and management can provide for his own retirement—any other way means a loss of independence."

And a Texas specialist gives his reason for saying "Yes" to coverage: "The realization that now at 60 I need it myself. And my position is probably representative of 75 percent of all physicians."

Senator DOUGLAS. Why is it, do you think, that the American Medical Association has refused to take a poll of its membership and so many of the State societies have taken polls?

Dr. SCHAMBERG. I can tell you why they say they have refused. They say that they elect a board of delegates to represent the grass-

roots, and that these delegates either will carry out the wishes of the grassroots or they will be voted out of office. This sounds very good on the surface, but is very bad when one digs a little deeper.

Very briefly, each county medical society elects delegates from the county to the State society. It is these delegates who are, for the most part, the hierarchy of medicine, it is this house of delegates of each State medical society which elects delegates to the—from the State to the American Medical Association.

Senator DOUGLAS. In other words, they have a system of indirect elections?

Dr. SCHAMBERG. Correct.

Senator DOUGLAS. Which form prevailed for the U.S. Senate until the direct election of Senators came in 1913; is that right? You are not acquainted with this; you are too young a man to remember it. [Laughter.]

But originally the U.S. Senators were chosen by the State legislatures and the State legislators were elected by the people. In other words, you had indirect election.

Now, I notice that it is stated in your supplementary evidence, that there are 202 delegates to the AMA.

Dr. SCHAMBERG That is right.

Senator DOUGLAS. That in the States which have voted in favor of inclusion there are 110 delegates.

Now, that does include California, where there was an Honest Ballot Association poll, and Missouri, where there was an Honest Ballot Association poll, and where there was a ratio of 1 to 10, and of 1 to 5, respectively. But it also includes New York, and you do not have any totals given for New York.

What are the figures for New York?

Dr. SCHAMBERG. The figures for New York are not available. New York State is placed in the favorable category because many of the counties in New York State have held polls and taken resolutions themselves, and the vast majority or all of these polls, I am not certain which, voted—the majority voted in favor of social security for physicians.

Senator DOUGLAS. Could you introduce material on New York for the record because this is a very important point? A great many of us have been reluctant to bring the doctors in against their will, and——

Senator LONG. If I might just suggest it, we might get on with the matter, I think that the evidence pretty well indicates that the overwhelming majority of polls, particularly those taken without pressure from the doctor organizations, seem to prefer this coverage. I would urge that any additional polls the doctor can secure or that the Senator can obtain from other sources be made available to us as soon as possible, and we will attempt to put them in the record.

I am hoping we will move ahead rapidly enough with this legislation so that we can act on it within the next 3 weeks in the Senate. That being the case, we would like to have these polls as soon as possible because we will put in the record the information that we can obtain prior to the time that we start printing. But by the time we start printing it, we will simply have to ask that additional material be added as a supplementary report for insertion in the record when the bill is debated.

Senator DOUGLAS. I think the chairman is very fair in his statement. I would like to follow this up a bit in New York.

Now, as I understand it there are separate AMA chapters in the various counties and boroughs.

Do you know what the vote would be in the Borough of Manhattan, if you were to take a poll in the Borough of Manhattan?

Dr. SCHAMBERG. I don't know.

Senator DOUGLAS. Do you know what the result was of the poll held in the Bronx?

Dr. SCHAMBERG. I do not know the results of any of these polls.

Senator DOUGLAS. Or in Queens?

Dr. SCHAMBERG. No; I do not.

Senator DOUGLAS. Or in Kings?

Dr. SCHAMBERG. No.

Senator DOUGLAS. Or in Richmond, or in Erie, Buffalo? Do you have material on this?

Mrs. ROST. Well, I think it will be easy to establish these polls and resolutions. The reason why the polls were not taken by the State society could be that by that time the AMA had discouraged the State societies from polling. The first State society polls were taken on suggestion of the AMA but when the AMA saw the results they discouraged taking them. That is why many small States haven't.

Senator DOUGLAS. Perhaps I should withhold my questioning until you take the stand. But I would like to have more information on the votes by counties——

Mrs. ROST. I know that Manhattan——

Senator DOUGLAS. And by the boroughs in New York City.

Mrs. ROST. I know Manhattan, the metropolitan area, is strongly in favor based mostly on resolutions, not polls.

Senator DOUGLAS. New York casts 24 votes in the House of Delegates of the American Medical Association and without New York there would only be 86 votes in favor, even counting California and Missouri, and assuming that the State society polls in the other States were unbiased and should have precedence over the honest ballot poll except in Illinois. I chose the honest ballot poll in Illinois because under the honest ballot poll the voters were not identified.

(The following telegram was subsequently received giving information on this question:)

NEW YORK, N.Y., *May 17, 1965.*

Mrs. ELIZABETH SPRINGER,
Chief Clerk, Senate Finance Committee,
New Senate Office Building,
Washington, D.C.

1. New York State Medical Society is on record as favoring inclusion of physicians under social security. Position taken at several annual meetings of the State society. Resolution was adopted after having been adopted by several county societies.

2. Re statement in Dr. Schamberg's testimony that 62.5 percent of physicians voting were in favor of social security coverage, use page 403, hearings before the Committee on Finance, U.S. Senate, 88th Congress, 2d session, on H.R. 11865, exhibit A.

COMMITTEE ON SOCIAL SECURITY FOR PHYSICIANS,
510 Madison Avenue, New York, N.Y.

Dr. SCHAMBERG. Senator Douglas, on this question of whether or not physicians are willing to be identified with their point of view,

as a delegate from the Philadelphia County Medical Society to the State medical, I introduced a resolution, as I mentioned before, asking that the Pennsylvania Medical Society instruct its delegates to the House of Delegates of the American Medical Association to request the AMA to come out in favor of social security for physicians.

I stood up on the floor of the House of Delegates of the Pennsylvania Medical Society and said:

> If well over 60 out of a hundred of all the physicians in Pennsylvania voted in the secret mail ballot—voted in the mail ballot which I believe was secret in favor of social security—I think there must be many men here who are delegates who favored social security. I would like to ask these men to have the courage of their convictions and to stand up and be counted, and I, therefore, request of the speaker that a standing vote rather than a voice vote be carried out.

Senator DOUGLAS. How many stood up?

Dr. SCHAMBERG. I sat down. The speaker said: Well, this would require a motion, so from way off in the end of the hall, I couldn't see who it was, someone said, "I move that we have a voice vote."

Immediately there were at least 2 dozen seconds to that motion and it was overwhelmingly voted. There was a voice vote and the men who I am sure had voted in favor of social security coverage in the privacy of their own offices, were unwilling to stand up and be counted. I think this is germane to your question as to whether or not our post-card votes were signed.

If they were signed the results would have been more opposed to social security because apparently from my experience in the State society a number of physicians for some reason or other are unwilling to be identified.

Senator DOUGLAS. Will you verify the question as to whether the ballots circulated by the Pennsylvania Medical Society were such that the individual could be identified, whehter by number or name?

Dr. SCHAMBERG. I will, indeed, and may I make sure that I have all of the data that you wish? You would like me to explain the difference between the Pennsylvania poll printed with my testimony and the numbers——

Senator DOUGLAS. Both were in favor of inclusion?

Dr. SCHAMBERG. Yes.

Senator DOUGLAS. But the majority under your poll, which you cited, was much greater.

Dr. SCHAMBERG. You would like the explanation for the difference between those. You would like——

Senator DOUGLAS. Was your poll conducted by the Honest Ballot Association?

Dr. SCHAMBERG. No. Both polls in Pennsylvania—and the difference may be that one of these refers to one poll and the other to the other poll—both polls in Pennsylvania in which the majority favored social security coverage were conducted by the Pennsylvania State Medical Society.

Senator DOUGLAS. Did the Pennsylvania Medical Society disown the first poll which gave a large majority for inclusion? Have they published it officially?

Dr. SCHAMBERG. Oh, yes; the results of both polls have been published and I can can get those for you very easily. You would also

like the results of the first poll taken by the magazine, Medical Economics.

I turned over to you the results of the second poll, and you would also like the results of the poll made by the medical tabloid newspaper, Medical Tribune, and you would like to know how many counties in New York.

Senator DOUGLAS. And in particular whether the big metropolitan boroughs were included.

Dr. SCHAMBERG. I know that the Borough of Manhattan was included, and was overwhelmingly in favor of social security coverage.

(The following was later received for the record:)

JENKINTOWN, PA., *May 18, 1965.*

MRS. ELIZABETH SPRINGER,
Chief Clerk, Senate Finance Committee,
New Senate Office Building, 2227, Washington, D.C.:

Pennsylvania Medical Society held two mail polls on compulsory social security for physicians; both anonymous. In 1959, 5,605 favored; 3,335 opposed. In 1961, 4,729 favored; 3,720 opposed.

IRA LEO SCHAMBERG, M.D.

Senator DOUGLAS. Thank you.

In the absence of the chairman I will call the next witness, please, Mrs. Gertrude S. Rost, of Orange, N.J.

Doctor, won't you sit up with Mrs. Rost?

STATEMENT OF MRS. GERTRUDE S. ROST, ORANGE, N.J.

Mrs. ROST. Mr. Chairman, and members of the committee, my name is Gertrude Sander Rost. I am the wife of Dr. Adolf S. Rost, a physician in private practice in Orange, N.J. Our son, Dr. Michael S. Rost, is a physician in Freeport, Long Island, is married, and has three children. Therefore, the desire of physicians for inclusion under social security and their need for it are familiar problems for me, from the retirement, as well as from the survivor benefit point of view.

Six years ago a physician's wife in my neighborhood told me about her husband, an M.D. in Newark, N.J., who had long been suffering from a chronic illness; he tried to practice part time but was finally forced to stop altogether.

Unable to leave him alone for more than an hour or two, his wife could not take a job. After a few years, they had spent their savings and are now entirely dependent on their only child, a daughter, who earns a modest living as a secretary.

"When do you think, Mrs. Rost, physicians will finally get social security?" she anxiously asked me. I did not have the heart to tell her that whenever it might come, it would be too late for them because her husband was no longer in practice.

Senator DOUGLAS. Mrs. Rost, this is true so far as cash benefits are concerned, but hospital and nursing home costs would be blanketed in. So he would be blanketed in under the provisions of the so-called medicare bill, plan A, and also on payment of $3 a month he would come in for medical and surgery benefits.

Mrs. ROST. This was 6 years ago when I talked to her.

Senator DOUGLAS. Yes.

Mrs. ROST. It was then that I decided to do something about it. Serious illnesses, especially heart attacks, seem to be frequent among middle-aged physicians, perhaps because of long hours, tremendous responsibility, and tension connected with their work. I have here a letter from Dr. H. C. Van der Meulen, of Pella, Iowa. Dr. Van der Meulen counted the physicians who died in 1964, as listed in the Journal of the American Medical Association and discovered that 40 percent had died before the age of 65. A tragic and dramatic example of this was the sudden death last year of Dr. Welch, then president of the AMA, who died at the age of 60, shortly after testifying before this committee.

More than half the retired M.D.'s who responded to a recent spot check by the magazine, Medical Economics, said they were forced out of practice for reasons of health, typically at the age of 68.

These facts certainly contradict the main argument against coverage of the AMA that doctors don't retired before the age of 72 and social security would be of little or no benefit.

The same Iowa physician, in another letter, refers to himself as belonging to "the little people." Coming from a physician, this may sound strange to many ears as the public image of the American physician is one of a man of almost limitless means. Certainly there are wealthy physicians; many others make a good living; others yet a modest one. There just is no universal picture as to physicians' financial circumstances and even the wealthiest one is as vulnerable to the hazards of life as everyone else.

The voices of physicians who want and ask for the protection of social security are growing louder and louder—in letters to Congress, in letters to the editor, and in medical publications.

I have here a short editorial, which I also respectfully submit to this committee, written by a physician in the Westchester County Medical Bulletin, New York, from which I quote:

The longer we delay acceptance [of social security], the more of us will retire, the more will become disabled, the more will die leaving young families without adequate savings and without the solid benefits currently taken for granted by virtually all our fellow citizens.

Senator DOUGLAS. Mrs. Rost, do you have the text of this editorial?

Mrs. ROST. Yes.

Senator DOUGLAS. Will you submit that for the record?

Mrs. ROST. Yes.

(The editorial referred to follows:)

[Westchester Medical Bulletin, Westchester County Medical Society, April 1965]

THE NOSE AND THE FACE

In all our deliberations it is curious that there seldom arises a question which profoundly affects the financial position of all physicians, singly and collectively: our exclusion from social security. The matter is again to be considered for congressional action and it's high time it were openly discussed.

Social security is not only a very low cost retirement plan; it is also no-nonsense permanent disability and life insurance. Every other profession has accepted the plan; but exuding an aura of impenetrable wisdom, we, like the cheese, stand alone. Let us be realistic. In America of this midcentury it is difficult, often impossible, to accumulate capital equal to that represented, at 4 percent interest, by maximum social security benefits. For man and wife it

amounts to at least $50,000, after taxes. "After" taxes, doctor. And that 4 percent interest is itself taxable. Social security payments are not. Provided through private insurance, such income for retirement, for permanent disability, for one's widow and minor children would be staggeringly expensive. Whatever the reasons for our past rejection of social security, they could hardly have been economic; if moral, they could hardly have escaped the quixotic. The longer we delay acceptance, the more of us will retire, the more will become disabled, the more will die leaving young families without adequate savings and without the solid benefits currently taken for granted by virtually all our fellow citizens.

It would be sheer obtuseness for any physician to fail to study objectively both the provisions and limitations of the plan. The time for decision comes again and concise information is readily available at your nearest social security office. The Advisory Committee on Social Security strongly recommends our inclusion; the House Ways and Means Committee approves. But the Senate Finance Committee is opposed, largely because of our past official position. And, therefore, doctor, never send to know whose face the nose spiteth; it spiteth thine own.

Mrs. ROST. In this connection I would like to read for you a letter of which I have a photostatic copy. It was written by the president of our New Jersey State Medical Society on September 11, 1964, to the chairman of the House Ways and Means Committee. While stressing his opposition to medicare, he writes to Mr. Mills:

For your information and guidance, I also would like you to know that the Medical Society of New Jersey urges the inclusion of physicians under social security.

Senator DOUGLAS. Would you submit that letter for the record?

(The letter referred to follows:)

THE MEDICAL SOCIETY OF NEW JERSEY,
Trenton 8, N.J., September 11, 1964.

Hon. WILBUR MILLS,
Chairman, Ways and Means Committee,
House of Representatives Office Building, Washington, D.C.:

As president of the Medical Society of New Jersey, I thank you and commend you for consistently resisting the indiscriminate inclusion under the social security program of limited hospital services for all social security beneficiaries over 61 years of age. In the name of all our members and of our women's auxiliary, I beg you to continue to resist such undesirable and unfair legislative action.

For your information and guidance, I also would like you to know that the Medical Society of New Jersey urges the inclusion of physicians under social security. We do not oppose social security, therefore, as such; but we do oppose the so-called medicare program.

Thank you for your fine work.

CHARLES CALVIN, M.D.,
President, Medical Society of New Jersey.

Mrs. ROST. I told this committee last year that most medical societies have some system for aiding needy physicians and their families or survivors. I am most aware of the situation in three States: New Jersey, New York, and Pennsylvania.

In New Jersey there is the Society for Relief of the Widows and Orphans of Medical Men of New Jersey. I have here a fund-raising letter from the Physicians' Home in New York, dated May 15, 1964, which states that, at the current rate, the monthly assistance to indigent doctors and their wives, widows, and dependents would exceed the previous year's aid by about 12 percent.

The most moving stories are provided by the Aid Association of the Philadelphia County Medical Society. Page 2 of the 1963 annual

report explains that "these are elderly physicians and wives or children who had no opportunity to contribute to social security etc. * * *, and who have exhausted their own resources."

Page 4 of the 1961 annual report tells of a 93-year-old physician and his wife, well over 80 years of age, who were granted desperately needed assistance. It took a great deal of persuasion on the part of the society to overcome the old people's pride.

Another report tells of a 35-year-old widow of a physician and her seven children who were also granted immediate aid. There are thank-you letters from elderly physicians' widows for a warm sweater or a used television set.

An 83-year-old physician's widow offers thanks for a Christmas check; the young daughter of a deceased physician, a college student, expressed gratitude for financial help; an elderly crippled physician and his wife give thanks for an increase in their monthly assistance—I could go on and on with these stories, but in essence they are all the same, revealing proud people, hit by sickness, death, or other misfortune, and forced to accept charity which they would not need if they were not excluded from social security.

Senator DOUGLAS. Will you furnish the text of these statements.

Mrs. ROST. I have them.

Senator DOUGLAS. From the Aid Assosciation of Philadelphia County Medical Association?

Mrs. ROST. I have the reports from Philadelphia and also have some papers.

Senator DOUGLAS. Mr. Chairman, I ask that these be made a part of Mrs. Rost's testimony.

Senator LONG. Yes.

(Mrs. Rost submitted four annual reports of the Aid Association of the Philadelphia County Medical Society, for the years 1960, 1961, 1962, and 1963, in which the cases referred to were mentioned. These annual reports were made a part of the committee files.)

Mrs. ROST. This brings me to a request which I respectfully submit to the members of this committee for earnest consideration, to have the inclusion of physicians under social security made retroactive as suggested by Dr. Schamberg. After so many years of anxious waiting, it seems cruel to see the door finally open and not to be allowed to enter immediately.

Young physicians, with small children, are particularly anxious to see social security coverage made retroactive. They are not yet in a position to carry substantial life insurance. Many of them are still repaying loans for their expensive education or for their equally expensive office equipment. They know that death may come to them just as unexpectedly as to anyone else and they want to be freed from their worry about their young families.

Please make physicians coverage effective January 1, 1965, just as the bill does in other cases, as for instance for benefits of children attending school beyond age 18. Since physicians file their tax returns by April 15 following their taxable years, there will be no problem of the taxpayment for every point of view. I repeat, please, do not let them wait for 2 more long and anxious years.

Considering the fact that physicians are the only professional group excluded from social security and have already waited for so many

years, I do not feel that our request is unreasonable, and we, the physicians' wives, our husbands, and our children would be deeply grateful for a favorable descision on this proposal.

I must ask the members of this committee for forgiveness if I have sounded emotional at times, but whatever I have stressed from an emotional point of view must also be considered from a highly practical one; it is well nigh impossible to separate the two. Let me conclude by pleading with you for help; pleading in the name of thousands of physicians and their wives all over the country, in the name of those among them whose pride might be broken, someday, by having to accept charity, and in the name of future physicians' widows and orphans who would have nowhere to turn in their need. Give them the protection which other Americans enjoy, protection by social security.

Thank you.

Senator LONG. Thank you very much.

Senator DOUGLAS. Mrs. Rost, I have a great deal of sympathy with your proposal and if these polls are borne out it is my intention to vote for inclusion. But I think you go pretty far in wanting to make this retroactive. I would like to say many of us would have supported this in the past had it not been for our belief that the majority of the doctors were opposed to it. We considered the opinions of the American Medical Association and we felt they expressed the opinion of the society. I have always believed that a group of this sort had the right to commit economic suicide if it so desired, and that if it was the desire of the medical profession that they should not be included I certainly did not want to overrule that desire.

Now, if this is not the real case, then we should reconsider. But here you have the testimony of your associates that although the polls were in favor of the inclusion of doctors in Pennsylvania, no one except Dr. Schamberg had the courage to stand up on the floor.

Do you think the people who lack courage and who do not have the intestinal fortitude to stand up for what they may believe to be right should be given extra protection?

Mrs. ROST. No.

Senator DOUGLAS. You do?

Mrs. ROST. No, I don't do that. But you must not forget, Senator Douglas, that a physician depends greatly on the local society; unless he is a member of that society he does not get hospital privileges, and so forth. I am sorry that you feel that doctors have no courage.

I know doctors who have much courage, and if this bill is not—if the provision is not made retroactive just those doctors who started fighting for it in 1950 will be the hardest hit because by now they are in the middle of their seventies, and would have to work another——

Senator DOUGLAS. The experiences of the last 30 years have made me feel that indifference and lack of courage is one of the greatest evils in society, and I think we have all been shocked by the way people will feel detached and will permit acts of violence to occur right before them without ever making any effort to help the person who is attacked, saying, "It is not my responsibility."

Now, here you have members of one of the great and revered professions not having the courage to state publicly what they believe in privately. This is a cancer inside our society, I don't know any way to produce a better attitude than for people to feel that if they take this attitude they must bear some of the penalties of it, but here you are asking for special treatment for a group which does not have the courage to speak up for itself.

Now, Dr. Schamberg does, and I want to commend him and you, too. But—yes, go ahead.

Dr. SCHAMBERG. Might I ask whether the sins of the American Medical Association should be visited upon the widows and orphans of doctors?

Senator DOUGLAS. Well, the failure of the doctors to protect their widows and orphans, I think, is quite striking.

Mrs. ROST. But, Senator Douglas, only about 78 percent of the physicians belong to the American Medical Association. There are about 22 percent of doctors who do not belong to the American Medical Association, who have never been heard and never been considered here in this committee; and 22 percent is quite a great number of physicians.

Now, the American Medical Association requires membership in some States, as a condition for membership in the local societies—for a physician it is necessary to belong to the county medical society for hospital privileges, and so forth, without which——

Senator DOUGLAS. Have they been able to pass any laws to that effect? The lawyers frequently get this provision, what they call an integrated bar in which membership is compulsory; have any States——

Mrs. ROST. I only know that in New York State the AMA has made it compulsory that the members of the county and state societies are also members of the American Medical Association.

Senator DOUGLAS. Hasn't this always prevailed.

Mrs. ROST. That is not the case in New Jersey.

Senator DOUGLAS. I thought when you joined the county society you automatically joined the State society and AMA, too.

Mrs. ROST. No; not the AMA, and we have many physicians in New Jersey who have left the AMA as a protest for the way the AMA represented their wishes.

Senator DOUGLAS. And they belong to the county societies?

Mrs. ROST. They must belong to the county societies.

Senator DOUGLAS. Dr. Schamberg.

Dr. SCHAMBERG. I may have misunderstood your question. There are now either 10 or 11 States which require membership in the American Medical Association for all members of the State medical society.

Senator DOUGLAS. Yes.

Dr. SCHAMBERG. I believe——

Senator DOUGLAS. Is membership in the State society voluntary or is it automatic upon being admitted to the profession?

Dr. SCHAMBERG. Membership in the county medical society requires, I believe, membership in the State medical society.

Senator DOUGLAS. I understand that.

The question is whether upon the admission to the practice of medicine a doctor has to belong to the county medical society?

Dr. SCHAMBERG. In many counties being on the staff of a hospital requires membership in the State and county medical society.

Senator DOUGLAS. Is this by State law or by practice of the hospital?

Dr. SCHAMBERG. No; this is by ruling of the State medical society.

Senator DOUGLAS. To the degree this exists; it is a closed shop, is it not?

Dr. SCHAMBERG. It is.

Mrs. ROST. It is not possible in New Jersey to get hospital privileges for a physician unless he belongs to the county society. But he is not compelled to belong to the American Medical Association.

Senator DOUGLAS. I understand.

Mrs. ROST. In New York State you have to be a member of the AMA.

Senator DOUGLAS. Would you say that is a closed shop?

Mrs. ROST. Well, as far as—

Senator DOUGLAS. Or a union shop, perhaps a union shop would be better.

Mrs. ROST. In a way, I would have to say "Yes". But I must always emphasize that not all physicians belong to the American Medical Association.

Senator DOUGLAS. In other words, what you say is that the AMA does not represent the opinion of physicians, necessarily.

Mrs. ROST. I would say they don't.

Senator DOUGLAS. On this issue.

Mrs. ROST. Yes; on this issue.

Senator DOUGLAS. Do you find that the physicians who favor inclusion for social security purposes are in favor of medicare or against medicare?

Mrs. ROST. Well, I don't think it has very much to do with it really.

Senator DOUGLAS. Logically it doesn't. But I was curious whether they wanted protection for themselves but did not want protection for others.

Mrs. ROST. Well, many of them are and many of them are not. I know that our committee on social security for physicians got contributions from physicians of whom we knew that they were not in favor of medicare. I mean it is——

Senator DOUGLAS. Your are yourself not in favor of medicare?

Mrs. ROST. I am very much in favor of medicare.

Senator DOUGLAS. You are?

Mrs. ROST. I have always been in favor and expressed that in a letter to the President a year ago to which he answered very graciously.

Senator DOUGLAS. You have never taken a poll amongst the supporters of inclusion under social security of how they feel on medicare?

Mrs. ROST. I don't—you see, Senator Douglas, our organization, the committee on social security, is a very loosely organized group and we don't have very great financial means.

Senator DOUGLAS. You have enough trouble of your own on this issue so you don't want to take on an added burden?

Mrs. ROST. We don't have the financial means to do that. We depend on voluntary contributions besides our only purpose is social security for physicians. Once this is achieved, the committee will be disbanded.

Senator DOUGLAS. Yes; I understand.

Dr. SCHAMBERG. I might add, Senator Douglas, that many times in the last few years I have read and heard the statement

How can we physicians ask to feed at the public trough, how can we ask for social security for ourselves and in good faith oppose medicare.

Senator DOUGLAS. That question was in back of my mind.

Dr. SCHAMBERG. To me this is complete nonsense but I have heard it asked a number of times.

Senator DOUGLAS. You think this question is complete nonsense?

Dr SCHAMBERG. Yes.

Senator DOUGLAS. Then you are opposed to medicare?

Dr. SCHAMBERG. No.

Senator DOUGLAS. You mean that to be opposed to medicare and at the same time be in favor of including doctors under social security is nonsense?

Dr. SCHAMBERG. To those who bow to the AMA line in opposing social security for physicians and opposing medicare, now they have one added arrow in their quiver.

Senator DOUGLAS. Quiver, the word is quiver, one more arrow in their quiver.

Dr. SCHAMBERG. They have now one more arrow in their quiver against social security for physicians; namely, how can we ask to feed at the public trough and still oppose medicare for all the rest of the American people.

Senator DOUGLAS. This is used as an argument that since doctors should not be in favor of medicare, they should not be in favor of inclusion in social security.

Dr. SCHAMBERG. Yes.

Senator DOUGLAS. I think the AMA posed a very good question.

Mrs. ROST. To prove that these two issues are not necessarily connected; I would like to read the whole letter from the president of our medical society to Mr. Mills: he writes:

As president of the Medical Society of New Jersey, I thank you and commend you—

that was last year—

I commend you for consistently resisting the independent discriminate inclusion under the social security program of limited hospital services for all social security beneficiaries over 61 years of age. In the name of all our members and of our women's auxiliary, I beg you to resist such undesirable and unfair legislative action.

Then he continues:

For your information and guidance, I also would like you to know that the medical society of New Jersey urges the inclusion of physicians under social security. We do not oppose social security, therefore, as such; but we do oppose the so-called medicare program.

Senator DOUGLAS. May I look at that letter, please?

In other words, the president of the Medical Society of New Jersey says he is in favor of including physicians under social security but he is opposed to limited hospital services for all social security beneficiaries.

Mrs. ROST. That is right.

You asked me if it goes hand in hand. It goes with us but not with everybody because they see some things wrong with medicare.

In other words they are not opposed to social security per se.

Senator DOUGLAS. I think this should be made a part of the record.

Mrs. ROST. This is a very unusual letter and I am very proud of our State Society.

Senator DOUGLAS. But your expressing, so clearly, the wishes of New Jersey poll physicians with regard to social security showed a vote in New Jersey of 2,174 in favor of inclusion, as compared with 916 against.

Mrs. ROST. Yes and I know that was an anonymous poll. My husband did not sign a card, just filled in the answer and sent it back. It was not a poll where the doctor could be identified.

Senator DOUGLAS. Let the record show Mrs. Rost says she does have a letter which is submitted, that comes from the Medical and Chirurgical Faculty of Maryland.

Mrs. ROST. It refers to your question of why doctors are dependent on their medical society and why they sometimes don't have enough courage to stand up for their convictions. Here I have a letter where the Medical and Chirurgical Faculty of the State of Maryland would withdraw certain privileges from their members unless they pay $50 as the delegates assessed them to do. The doctors in this particular case——

Senator DOUGLAS. What was this $50 for?

Mrs. ROST. To fight medicare. And in this case the doctors stood up, asked that this assessment would be rescinded and they also asked in this connection for a poll if physicians wanted social security, and asked the AMA to return the $10 million to the tobacco industry. These were three resolutions brought in by the great majority of the physicians. The doctor who sent me this letter writes that he has hardly ever seen such attendance at a meeting of the Medical Society of the State of Maryland. How it came out, I don't know because the newspapers in Baltimore were on strike after that, and were not published, but the initial issue that I just mentioned was published in the Baltimore Sun and I think it might be interesting to submit this to the record.

Senator DOUGLAS. Thank you very much.

(The letter referred to follows:)

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND,
Baltimore, Md., March 10, 1965.

DEAR FELLOW MEMBERS: A $50 assessment on all active members of the faculty who have been in practice for 3 or more years was approved by the house of delegates on February 20. This assessment is due and payable within 60 days in accordance with the bylaws, article III, section 6.

This letter explains the reasons for the special assessment. You may have drawn a somewhat different conclusion from the accounts in the public press.

A 2- to 3-year public service program of information and education was the question put to the house of delegates. Slightly less than 20 percent of the total assessment will be expended in our effort to tell the Maryland public the true facts about the medicare tax plan impending in Congress and the more comprehensive doctors' eldercare plan (the Herlong-Curtis bill), favored by the American Medical Association.

A wide majority of the delegates voted in favor of the assessment. Among those who objected were members of a county society which already has a similar assessment upon its own members and who felt that each county society, rather than the faculty, should do this; those who felt that the denial of the rights to physician's defense for nonpayment of the assessment was not proper;

and some few who felt the antimedicare fight is hopeless, and that we are merely making matters worse by fighting.

Within 2 days of the newspaper and television publicity concerning our educational program, we received cash contributions from members of the public to assist us * * * we received dozens of telephone calls asking for material on the complete health care program offered through the doctors' eldercare plan * * * and we have received surprising and heartening encouragement from many other supporters of the medical profession's stand on this particular issue.

WHY A LONG-TERM INFORMATION AND EDUCATION PROGRAM?

Because something strange seems to have been happening in the relationships between the medical profession and the public in recent years. The high esteem in which doctors as a group were once held is being slowly sliced away. Surely, much of this lessening of respect for our profession results from our stanch stand against the federalization of medicine. For this, we are being pictured as "selfish and pugnacious," through caustic propaganda concerning our motivations.

The steady erosion of our former standing is not the result of our medicare position alone. In the complex, rapidly advancing world of modern medicine we have been too busy caring for our patients to properly communicate the steady changes that have been occurring on the one hand and our rigid principles on the other hand.

The wider the gulf becomes in patients' understanding of physicians, the more we lose their respect, and the more difficult it becomes for us to render efficacious health care.

Furthermore, we are faced with educating our State legislators toward improving not only payments to physicians but payments for all health care services. For too long, the practicing physician, as well as other purveyors of health care services, have been subsidizing the State government's operation. This amounts to a hidden tax that these groups are paying.

WHY AN ALL-OUT EDUCATIONAL PROGRAM ABOUT ELDERCARE AND MEDICARE?

Because some of our own members, not tc mention the vast majority of the general public, are woefully ignorant about the inadequacies of this seemingly harmless menance to good medicine. It is our solemn obligation as physicians to speak out against this threat to the American system of medicine and the American way of life.

The proponents of the 60-day hospital care program make no secret of the fact that they intend to expand it into a program of complete socialized medicine. We doctors know this will not work, will result in a lowering of standards of the high-quality care now rendered to the public, and will result in the placing of the physician in a category of low-grade civil servant.

As this is written, the proponents of the administration's program have, once again, increased their estimated cost of such a program—to $3.7 billion a year by 1977, causing the House Ways and Means Committee to make an attempt to reduce cash benefits under the social security system. Need I say more.

No matter what type of medical or health care program is adopted by the U.S. Congress this year, we must continue to work toward one that will offer those in need of a comprehensive health care program—with no means test, with payment for physicians' services, drug costs, and other services.

I apologize for the length of this communication. You must know the facts, however, and realize the necessity for this drastic action by your council and house of delegates. It is anticipated that this $50 will be enough to finance the educational program for a 2- to 3-year period. By the end of this time, we will know how successful we have been.

ALBERT E. GOLDSTEIN, M.D.,
President.

BALTIMORE, MD., *April 12, 1965.*

PHYSICIANS FORUM,

GENTLEMEN: Kindly send literature to the following physicians, if they are not on your list already. During our last State society meeting, the liberal view dominated as you can see by the following resolutions passed:

(1) To poll physicians on their opinion about social security for physicians—overwhelming majority.

(2) To recommend to the AMA to return the $1 million to the tobacco industry—overwhelming majority.

(3) To rescind the $50 assessment to fight medicare passed at the previous meeting of the Maryland House of Delegates—nine-tenths of those present (300) voted for rescinding.

I thought you might be interested to have the names of the physicians who took the floor to express the liberal point of view.

JULIUS C. GLUCK, M.D.

MEDICAL LEADERS MEET THIS WEEK—DECISION ON MEDICARE FEE SURE TO SPARK DEBATE

The State medical society's policy-making house of delegates will meet this week in the wake of a surprise vote by the Baltimore City Medical Society condemning its decision to assess Maryland physicians $50 each to help fight medicare.

Two months ago, the house of delegates in a heated special session voted to levy the $140,000 assessment on the State medical society's members for a public relations campaigning against medicare and a "continuing program of public education."

Two weeks ago, in what might be termed a "coup," a large group of dissident city doctors pushed through a resolution at a Baltimore City Medical Society meeting asking the house of delegates to rescind its action.

Although the city medical society's action is not binding on its delegates to the State society's annual meeting this week, the matter seems certain to come before the house of delegates, even though it is not on the house's official agenda.

On the scientific side of the three-day meeting, which opens Wednesday at the Alcazar, will be lectures on high-blood pressure, cancer of the cervix, hepatitis caused by blood transfusions, gout, birth control and other medical subjects.

Senator DOUGLAS. Any further questions?

Well thank you. Your testimony has been very interesting. I think if there is any representative of the American Medical Association here they should have the right to reply to these polls and make any statement that they wish.

Dr. ANDREWS. I am Dr. Elizabeth Terry Andrews, and I belong both to this organization and also to the American Medical Association and I am thoroughly behind this one. I am not opposing them in any way. I am very much interested in this testimony.

Senator DOUGLAS. The next witness is Mr. Cyrus T. Anderson of the International Union of Hotel & Restaurant Employees & Bartenders.

STATEMENT OF CYRUS T. ANDERSON, REPRESENTING INTERNATIONAL UNION OF HOTEL & RESTAURANT EMPLOYEES & BARTENDERS

Mr. ANDERSON. Mr. Chairman, my name is Cyrus T. Anderson, and I represent the Hotel & Restaurant Employees & Bartenders International Union, and I should like to apologize for not having a written statement. I have been out of my office for the last 2 weeks by reason of a personal illness.

With your indulgence, I should like to briefly summarize the position of the Hotel, Restaurant Workers & Bartenders International Union with respect to one provision in the House-passed bill which is now being considered by this committee. This is the provision having to do with the inclusion for social security tax purposes in the wage base of earnings deriving from gratuities or tips.

First of all, let me say this on behalf of this union, which has about 500,000 employees in all 50 of the States, that the Congress is now pro-

ceeding to move into a new concept of social insurance legislation. The Congress, using as its base the great social security system which is now well over 25 years old, using as its base the social security system, the Congress now proposes to move out and insure medical benefits for retired persons and elderly persons under the social security system.

We say to you hopefully that before you move into this new area, and before you conduct, as it were, a space probe, that you correct a basic defect in the present system which has existed for 25 years.

The lack of coverage of the people employed in the service industry is one which is recognized by experts throughout the Government and throughout the Congress. This is a problem which has been confronting these people for a long, long time. Efforts have been made to correct it; successful solution of the problem has never been found.

First of all, I should like to briefly discuss the opposition to this bill and to this part of the bill. The employers in their testimony in the House committees and in their private solicitations of Members of Congress seem to object to this bill for five reasons or this provision for five reasons.

First of all, they allege that the employer is, in fact, an innocent bystander between the waiter or the service employee, and the customer in this tip transaction, and that the employee is in a sense a self-employed person, and that this tip should not be part of the wage base.

Secondly, they assert that technical and administrative difficulties will arise in the administration of any such provision as this if it becomes law.

Thirdly, they allege that this industry is so heavily casual in its employment that is to say, so many people in this industry are casual employees, that it will be impossible of administration. Fourth, they say that this will impose upon the employees, poor, hard-working, low-income group employees, burdens beyond their capacity to handle.

Fifth and lastly, they allege that employees may adjust their reports under this section either upward or downward fitting their age situation. For example, if the employee is older he would cheat and increase his tip base in order to fatten up his social security entitlement, or if he is a younger man, he may be expected to cheat and shorten his report in order to save that amount of contribution under the tax.

I should like to discuss briefly each one of these five objections.

First, the objection that the employer is the innocent bystander, and that this should not be considered as part of the wage base. In the Congress at the moment there is a move underfoot to increase the minimum wage laws and to broaden their coverage. This move was afoot 2 years ago and 4 years ago. Two years ago when hearings on the question of coverage of hotel, restaurant, and service employees under the minimum wage laws were up in the House Labor Committee, spokesmen for the employers in this industry appeared before that committee and said in effect there is no need to cover these people for minimum wage purposes because they are, in fact earning more than a minimum wage, when you take into account the tips which are actually part of their income.

On the other hand, when they got over in front of Mr. Mills in the Ways and Means Committee in the House, they said these people are, in fact, self-employed people, and that the tips and gratuities are not

really part of the wage base and, therefore, should not be considered as such.

I think it is a fact that very recently in discussion in executive session in the Ways and Means Committee the employers in this industry were told rather forcefully by the chairman of the committee that "you can't have it both ways. You have either got to recognize this is a social security base earning or the minimum wage protection is needed, but you can't cover this thing both ways."

But I think categorically it is a fact that tips are part of the earnings in this industry, it is part of the income of these people, and when you talk about social security, you are talking about insuring against the loss of income upon retirement, and there is no question in our minds but what there can never be a fair social security system as it affects hotel, restaurant and service employees unless there is coverage for tipped employment.

Secondly, technical and administrative difficulty. There never has been a tax imposed on anybody by this Congress that hasn't given rise to technical and administrative difficulties. I rely in this situation on the fact that this international union has done everything that it could to cooperate with the Treasury of the United States in the drafting of this legislation. Every single suggestion made to us by Treasury we have accepted. We have got a complete, 100 percent record of cooperation with the Treasury, and everytime that they have, almost every time they have made a suggestion to us it has been in the interest of easing the administration of this law.

For example, a peculiar problem confronted the Marriott Motor Hotels, a substantial business headquartered here in Washington. There is a section, a portion, of the language in this particular section which is intended to ease the administrative problem of the Marriott Motor Hotels, so we are proud of our record in working with Treasury to try to make this thing easier.

If it becomes law, and if some problem is developed, we will be the first to come here to Congress and help try to get it corrected.

Hurriedly, casual employees. There is absolutely no basis in an allegation that this industry is so casual in its makeup that this is bad legislation.

The Department of Labor in a study made in February 1962 identified as "Restaurant and Other Food Service Enterprises Data Pertinent to an Evaluation of the Need for and the Feasibility of Applying Statutory Minimum Wage and Maximum Hour Standards," which is a very long title, but in any event in this study conducted by the Department of Labor at the request of the House Labor Committee, it was determined that there are 1,575,667 employees in the eating and drinking establishments of the United States. This is all inclusive. Furthermore, only 45,952 of this total number were casuals. Therefore, we believe that the statistical data of the Department of Labor completely refutes this allegation on the part——

Senator DOUGLAS. The casuals would be dishwashers primarily?

Mr. ANDERSON. No, Senator. Casuals are people who float in and out of the industry.

Senator DOUGLAS. I mean they congregate heavily in dishwashing; isn't that true?

Mr. ANDERSON. I believe this is so. But they also congregate in other areas. Casuals by definition are less skilled, and this is probably one of the lesser skills required in this industry.

Fourth, a burden on the employees. I sometimes think that the employers of this industry are terribly solicitous of their employees, especially when there is a problem that the employees are interested in. Any employer always becomes awfully interested in how the employees organizations are conducted, and whether or not their union elections are really fair, and many other things, and there is a concern here that we are talking about imposing a burden on our employees, and all I can say to you is that in the international conventions of this union, and in the deliberations of our local unions and of our joint councils in the various cities and States, this is the legislative program of this international union, to establish a system of law whereby, one, tipped employment is covered for social security purposes; and, two, whereby income taxes are paid on a quarterly basis by employees in the service industry.

Last week, the allegations that employees may adjust their reports to suit their particular situation. This is an allegation that might very well be made by anybody who has a tax liability. You could see if you were going to reduce or increase excise taxes on July 1, that there will be people involved in this business who won't be honest with this Government, and if there are people in our business who are not honest with their Government, there are provisions for taking care of it, and we do not think it is a valid objection.

In the first place, I do not think it is going to happen, but if it does, there are ways of taking care of it.

In closing, I would like to say again that we hope this committee will retain in this bill that section dealing with the establishment of a coverage for social security purposes of tipped employment; and, secondly, the inclusion in the Withholding Tax Act of income from tipped employment by persons in the service industry.

Thank you, sir.

Senator DOUGLAS. Thank you, Mr. Anderson. That is very cogent testimony.

The section in question, I take it, is section 313?

Mr. ANDERSON. Yes, sir.

Senator DOUGLAS. And, as I read it, that exempts tips in kind, not in cash, from covered tips, that is presents of boxes of candy or hams——

Mr. ANDERSON. That is correct; this is correct.

Senator DOUGLAS. And so forth, and also tips which, in a month, are less than $20.

Mr. ANDERSON. This is correct. These are regarded as casual tips.

Senator DOUGLAS. In a 5-day week it would be approximately $1 a day.

Mr. ANDERSON. Yes, sir.

Senator DOUGLAS. Did I understand you to say that if tips of this type are included in the computation of earnings for social security purposes, that you would be willing to have them included as wages under minimum wage provisions?

Mr. ANDERSON. Yes, sir. There will have to be some adjustment in the computation of a minimum wage standard in this industry, because it is a fact, Senator, that the waiter in the Purple Tree at the Hamilton

Hotel on Saturday night, when he goes home to talk to his wife about the week's earnings, talks not only about the $25 or $30 that the hotel gives him, he talks about the earnings he has picked up in cash tips, and this is part of the income in this business, and that is what we are talking about.

Senator DOUGLAS. I see there has been a sort of schizophrenia on both sides on this tip question.

Mr. ANDERSON. Not in the 4 years that I have been in the business, Senator. We have agreed to a figure——

Senator DOUGLAS. Not with you, Mr. Anderson, but I have heard this argument. The employers will want to have tips included so far as wage standards are concerned, but are not very anxious to have them included in social security.

But I have talked to people from the wage earners who would like to have these included under social security, but not considered with respect to wage standards.

Now, you are taking the consistent attitude that they should be included for both purposes in a uniform definition.

Mr. ANDERSON. Yes, sir; and we so testified before the House Labor Committee 2 years ago, and we would take that position now; yes, sir.

Senator DOUGLAS. That is the official position of the union?

Mr. ANDERSON. Yes, sir; it is.

Senator DOUGLAS. It is not only your position but the official position of the union.

Mr. ANDERSON. The testimony was actually given by the general counsel of our union directly representing the international union, as I do myself.

Senator DOUGLAS. Very good. This may clear up a lot of difficulties if you have uniformity both for wage standards and for social security provisions.

Now, have you talked with the social security people as to whether these reports ought to be monthly or quarterly?

Mr. ANDERSON. Quarterly.

Senator DOUGLAS. And whether this presents unusual administrative difficulties.

Mr. ANDERSON. Senator, I think it is a fair statement to say that this bill is written around the administrative challenges of the social security system; that this bill had to be written around the IBM computer complexes at their headquarters in Baltimore; and, yes, the answer is yes, we have not only cleared this with social security, we have met every requirement that they gave us.

Senator DOUGLAS. The tip feature would be the same, fundamentally the same, as the form for the self-employed workers.

Mr. ANDERSON. With some variation, yes, because there are features of tipped employment now existent which are in the control of the employer. For example, if you sign a tip on your American Express credit card or if you sign a tip on your hotel bill or if you engage a banquet at the Statler Hotel, part of your chit, part of the billing, that you receive covers service or tips for the employees. This is all within the control the employer. So that the man's reporting of tipped earnings will include not only the cash earnings that he declares, but also the other earnings that are actually in the control of the employer, so it is not exactly on a self-employed situation.

Senator DOUGLAS. That is, the 10 percent or 15 percent would be included, too?

Mr. ANDERSON. In this respect it differs from a self-employed situation.

Senator DOUGLAS. Well, thank you very much for very pertinent testimony.

Mr. ANDERSON. Thank you.

Senator DOUGLAS. The final witness this morning is Mr. James A. Mann, of the Illinois State Chamber of Commerce.

I am very glad to welcome you, Mr. Mann.

STATEMENT OF JAMES A. MANN, CHAIRMAN, SOCIAL SECURITY COMMITTEE, ILLINOIS STATE CHAMBER OF COMMERCE

Mr. MANN. Thank you, Senator Douglas. It is nice to have a Senator from Illinois present here today.

My name is James A. Mann. I am personnel manager for Wyman-Gordon Co., Ingalls-Shepard Division, Harvey, Ill., producers of drop forgings for the automotive, aircraft, truck and tractor industries. Currently, I am chairman of the Social Security Committee of the Illinois State Chamber of Commerce. At this time, I wish to briefly highlight certain portions of a statement I have previously prepared and submitted of your consideration.

Senator DOUGLAS. Your prepared statement will be inserted in the record following your oral testimony.

Mr. Mann, during past years, the Illinois State chamber has supported expansion and improvement of social security but has stressed that this essentially is a tax program wherein today's workers pay for the benefits of today's retired workers. As an organization of businessmen, we have been concerned with the costs of these programs, both present and future. I am sure that in your consideration of H.R. 6675 you necessarily will view this legislation from the point of view of taxes and costs as well as benefits essential to provide protection to our elderly.

In view of our concern over the costs of the social security program itself, we have questioned the incorporation of medical and hospital care for the elderly through a payroll tax in the social security system. It has been, and still is, our contention that providing hospital and medical care for the aged on the basis of "rights" under social security will jeopardize the social security program because of the high costs that will occur.

Senator DOUGLAS. You will forgive me, Mr. Mann, but you know that actuarially and financially the funds for hospital and medical care and, indeed, for surgical and medical care, are to be isolated from the general social security fund.

Mr. MANN. Yes, sir.

Senator DOUGLAS. Proceed.

Mr. MANN. I am sure you will fully consider the costs in the present bill as well as possible future costs through demands that will be made for further expansion of the medicare program. Some of these demands you already have received; for example, additional medical and surgical benefits beyond the scope of H.R. 6675 and the elimination of deductibles in hospital care.

It is the Illinois State chamber's firm position that medical and hospital care must be provided to our needy aged but it should be done on the basis of Federal-State cooperation with administration at the State and local levels. We have continually supported this type of protection and we are hopeful that your committee will approve provisions in H.R. 6675 implementing what is known as the Kerr-Mills program, providing medical care for the indigent.

In view of the volume of testimony you have received, I do not wish to burden you by restraining the many issues brought to your attention. However, there are three matters of concern which I specifically wish to point out.

When the Social Security Act was amended by Congress in 1956 providing disability benefits, Congress recognized that these new Federal payments would overlap with wage replacement benefits provided under workmen's compensation. This law stipulated that the social security disability payments would be offset or reduced by the amount of benefits paid under workmen's compensation in the various States. However, we believe an error was made when this offset provision was deleted from the Social Security Act in 1958. Section 303 of H.R. 6675 compounds this error by in effect allowing additional thousands of workers a double package of workmen's compensation and social security disability benefits for short-term temporary disabilities.

As explained in an example in my previous statement, under section 303 it will be possible in Illinois for an injured workman with two children to receive double monthly benefits of approximately $551—tax free—as compared to his previous wage of $400 a month.

We strongly feel that your committee should provide that social security disability benefits be offset by workmen's compensation payments in the various States and further that the present requirement that a worker's disability must be expected to result in death or to be of long continued and indefinite duration be maintained.

The Illinois State Chamber of Commerce believes that the individual States should finance any necessary expansion of public assistance programs for the needy aged, blind, disabled, and families with dependent children without further increases in Federal matching formulas. If Congress determines, however, that increased Federal payments are necessary, we wish to point out our concern regarding various provisions in H.R. 6675.

In discussions with the Illinois Department of Public Aid, we find that section 405 provides that a State will receive added Federal aid provided under title XIX and the added Federal aid for money payments provided in section 401 only to the extent that its total expenditures for medical assistance and money grants under the new system effective in 1966 exceed the average of its total expenditures for fiscal 1964 or 1965, whichever the State may select. This requirement will penalize States like Illinois whose cash grants, coupled with available resources, are considerably above the national average and provide a reasonable subsistence level now.

In order to correct this injustice, we suggest that the bill be amended to require that the Secretary of the Department of Health, Education, and Welfare establish a minimum standard for subsistence support which he shall use as a measure in determining whether or not a State shall be exempt from the section 405 formula for eligibility to receive

increased matching for money payments. In addition, the bill should be amended to exempt from the "maintenance of State effort" formula those States who already provide for money payment recipients the five medical services which will be mandatory as of July 1967.

We wish to bring to your attention three requirements in proposed title XIX of the Social Security Act which we oppose.

First, we oppose the provision that only the spouse of adult recipients and parents for children under 21 shall be considered responsible relatives. We believe that children and parents of adult recipients, as now provided under title XVI, should be included under title XIX as responsible relatives. In addition, brothers and sisters living in the same home of AFDC and general assistance recipients should be required to provide support according to their ability.

Second, we oppose the provision prohibiting a lien upon the property of a recipient. Illinois statutes currently provide that the State may oppose a lien upon the real property of recipients of old age, blind, or disability assistance. Inasmuch as the homestead and contiguous real estate of an individual is exempt in determining eligibility for both money payments and medical assistance in Illinois, we believe that the State should not be prohibited from establishing a lien on the real property of recipients mentioned above. The prohibition of the lien provision, in effect, provides for the creation of an estate at public expense.

The third requirement which concerns us would prohibit any durational residence requirement. Under all public assistance programs in Illinois, except the aid to medically indigent aged program under the Kerr-Mills Act, a person must reside in the State for 1 year as one of the conditions for eligibility. We support the 1-year residence requirement, and recommend that item (3) on page 136 of the bill be amended to authorize such a requirement for eligibility for medical assistance under programs covered by title XIX.

In discussions on H.R. 6675 with the Illinois Department of Public Aid, we share their concern that the "maintenance of State effort" formula appears to inject a philosophy into the public aid field that a State has to spend more to get more. We hope the Senate Finance Committee will remedy this situation by adopting the changes we have suggested.

In my previously prepared statement, I have explained our company's plans providing medical and hospital care to our retirees which they receive at no cost to them. These plans have been developed through collective bargaining agreements with five unions and we are particularly concerned as to the effect the medicare provisions in H.R. 6675 will have on these plans and future expansion of this nationwide voluntary insurance approach to the problem of providing assistance to retired workers. We trust your committee will give due consideration to this problem.

Frankly, it is difficult for me to forecast what effect the passage of medicare would have on future consideration of expansion of our program. In our situation, the combined employer-employee 1.6-percent social security tax for medicare is an additional unnecessary cost to our company and to our employees.

Thank you for your courteous attention, Senator Douglas.

(The prepared statement of Mr. Mann follows:)

STATEMENT OF JAMES A. MANN FOR THE ILLINOIS STATE CHAMBER OF COMMERCE

My name is James A. Mann. I am personnel manager for Wyman-Gordon Co., Ingalls-Shepard Division, Harvey, Ill., producers of drop forgings for the automotive, aircraft, truck, and tractor industries. Currently, I am chairman of the Social Security Committee of the Illinois State Chamber of Commerce.

This statement is presented on behalf of the Illinois State Chamber of Commerce, a statewide civic organization with a membership of about 20,000 businessmen, representing over 8,500 individual business enterprises in Illinois. Since 1952, I have been a member of the Illinois State Chamber's Social Security Committee which is comprised of 88 individuals, representing all types of business in our State, ranging from the self-employed to some of the Nation's largest corporations.

Our committee has constantly studied and reviewed matters relating to social security, and the policies which we recommend are approved by the State chamber's 70-member board of directors. Thus, my presentation and the viewpoints expressed in this statement, I am sure, are broadly representative of Illinois business.

COSTS AND TAXES

During past years, the Illinois State Chamber, through its social security committee, has supported expansion and improvement of social security but has stressed that this essentially is a tax program wherein today's workers pay for the benefits of today's retired workers. As an organization of businessmen, we have been concerned with the costs of these programs, both present and future. I am sure that in your consideration of H.R. 6675 you necessarily will view this legislation from the point of view of taxes and costs as well as benefits essential to provide protection to our elderly. With respect to taxes, they are taxes whether payroll, income, property, or excise and, of course, definitely affect our economy in a variety of ways. Let us just mention payroll taxes which are the concern of this legislation. They necessarily increase the costs of production when paid by the employer and the employee. In turn, such taxes contribute to an inflationary spiral throught an increase in the cost of living as they must become a part of the price paid for the goods and services produced.

Considering social security taxes alone, they can develop into what so often is termed "a vicious circle." An increased cost of living resulting from increased prices for goods and services will require an increase in benefits to the retired person. In turn, social security taxes, if we are to maintain today's adopted principles, will be increased with a further resulting increase in the cost of living. This appears to be recognized now in H.R. 6675 where benefits are increased to offset the increased cost of living. We recognize that such increases are necessary to maintain the basic purpose of the social security program. However, we cannot help but be concerned with the increased taxes that must accompany the increased benefits.

In view of our concern over the costs of the social security program itself, the State chamber has questioned the incorporation of a medical and hospital care for the elderly program through a payroll tax in the social security system. It has been, and still is, our contention that providing hospital and medical care for the aged on the basis of rights under social security will jeopardize the social security program because of the high cost that will occur.

By this time, your committee has analyzed these costs and I am sure you have similar concern. In past years, social security experts, including those in the Department of Health, Education, and Welfare, have warned that the social security tax should not exceed 10 percent of taxable payroll. However, as you well know, H.R. 6675 provides eventually for a 11.2 percent tax rate and that will be on an increased taxable wage base of $6,600. It is doubtful that anyone can forecast what the eventual tax will be with the inclusion of the medicare provisions.

We sincerely suggest that at this time, after you have determined whether or not it is wise to include medicare under social security, you resist all efforts to further increase the costs of what appears to be at least a $6 billion-a-year increase. Already, you have received suggestions to provide further medical and surgical benefits and to eliminate the deductibles in hospital care. Now, and in the future, there will be demands for increasing the maximum stay in hospitals, added payments for drugs and appliances, the lowering of the eligibility age for receiving benefits, and other provisions greatly increasing costs to staggering proportions. I am sure you are considering all these problems in your determinations as to the wisdom of placing medicare under social security.

We are hopeful that your committee will approve provisions implementing what is known as the Kerr-Mills provisions, providing medical care for the indigent. It is the Illinois State chamber's firm position that medical and hospital care must be provided to our needy aged and it should be done on the basis of Federal-State cooperation with administration at the State and local levels. We have continually supported this type of program and later will point out certain provisions which we feel will curtail the ability of State and local administration to function effectively in this field.

In view of the volume of testimony you have received, we do not wish to burden you by restating the many points brought to your attention. However, there are three matters of concern which we specifically wish to call to your attention.

SOCIAL SECURITY DISABILITY BENEFITS—WORKMEN'S COMPENSATION

You have heard much testimony concerning section 303 of the Social Security Amendments of 1965 (H.R. 6675). In our estimation, this section compounds an error made in 1958. It eliminates the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration and provides instead that an insured worker will be eligible for social security disability benefits if he has been totally disabled through a continuous period of at least 6 calendar months. Further, it provides that disability benefits would be payable beginning with the last month of the 6-month waiting period.

When the Social Security Act was amended by Congress in 1956 providing disability benefits, Congress recognized that these new Federal payments would overlap with wage-replacement benefits provided under workmen's compensation. This law stipulated that the social security disability payments would be "offset" or reduced by the amount of benefits paid under workmen's compensation in the various States. However, we believe an error was made when this "offset" provision was deleted from the Social Security Act in 1958. Section 303 of H.R. 6675 compounds this error by in effect allowing additional thousands of workers a double package of workmen's compensation and social security disability benefits for short-term temporary disabilities.

I would like to point out what could happen in Illinois under this provision. Workmen's compensation benefits are to be substantially increased in our State this year. For example, an individual who becomes temporarily totally disabled and has two dependent children will be able to receive as much as $69 a week. He may receive this for 64 weeks. Assuming he had wages of $4,800 a year, under H.R. 6675 he will be eligible to receive family benefits of $271.80 for his disability after 5 months. Combine this with his workmen's compensation benefits of at least $280 a month and this worker could receive, from the two benefit systems, monthly payments of at least $551.80 until his 64-week period of temporary total benefits have been exhausted in Illinois. I am sure you know that his medical and hospital expenses are paid during this period under workmen's compensation and that the benefits are tax free.

To use even more conservative figures, the average social security disability monthly payment as of January 1964 (Social Security Bulletin, May 1964, vol. 27, No. 5, p. 32) would amount to $185.18 for an individual with a wife and two children. Adding the 7 percent benefit increase in H.R. 6675, it appears that this beneficiary would receive an average monthly disability benefit of at least $198.14 under the provisions in H.R. 6675. In this instance, his combined benefits would amount to approximately $478 per month as compared to the monthly wage of $400 or less. This becomes further exaggerated as top weekly workmen's compensation benefits in Illinois will be $76 for the individual with the same earnings and four children.

There is general agreement that everything should be done to rehabilitate an injured worker and to provide incentives for him to return to work. We firmly believe that the average disabled worker desires active employment rather than the idle drawing of benefits; however, it appears that there would be a tremendous incentive for individuals to accept monthly benefits (tax free) considerably in excess of his earnings.

We strongly feel that your committee should provide that these social security disability benefits be offset by workmen's compensation payments in the various States and further that the present requirement that a worker's disability must be expected to result in death or to be of long continued and indefinite duration be maintained.

REVISIONS AFFECTING PUBLIC ASSISTANCE TITLES OF THE SOCIAL SECURITY ACT

The Illinois State Chamber of Commerce believes that the individual States should finance any necessary expansion of public assistance programs for the needy aged, blind, disabled, and families with dependent children without further increases in Federal-matching formulas. Local and State administrators in each State are closer to the needs of public assistance recipients and other needy individuals. They are also acutely aware of the ability of taxpayers within their respective States to finance expanded medical assistance and grant benefits. If Federal funds were not available, many States would not be pushing to expand medical services and grants so rapidly. If Congress determines, however, that increased Federal payments are necessary, we wish to point out our concern regarding various provisions in H.R. 6675.

TITLE IV, PUBLIC ASSISTANCE, AMENDMENTS, SECTION 405, MAINTENANCE OF STATE PUBLIC ASSISTANCE EXPENDITURES

In discussions with the Illinois Department of Public Aid, we find that section 405 provides that a State will receive added Federal and provided under title XIX and the added Federal aid for money payments provided in section 401 only to the extent that its total expenditures for medical assistance and money grants under the new system effective in 1966 exceed the average of its total expenditures for fiscal 1964 or 1965, whichever the State may select. This requirement will penalize States like Illinois whose cash grants, coupled with available resources, are considerably above the national average and provide a reasonable subsistence level now. It will have the same effect where comprehensive medical care has been provided public aid recipients for a number of years, and where a State has forged ahead in implementing a program of aid to medically indigent, both for the aged (under Kerr-Mills) and for the group under 65 provided for by local and State funds.

In order to correct this injustice, we suggest that the bill be amended to require that the Secretary of the Department of Health, Education, and Welfare establish a minimum standard for subsistence support which he shall use as a measure in determining whether or not a State shall be exempt from the section 405 formula for eligibility to receive increased matching for money payments. In addition, the bill should be amended to exempt from the "Maintenance of State effort" formula those States who already provide for money payment recipients the five medical services which will be mandatory as of July 1967.

TITLE XIX, GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

We wish to bring to your attention three requirements in proposed title XIX of the Social Security Act which we oppose.

First, we oppose the provision that only the spouse of adult recipients and parents for children under 21 shall be considered responsible relatives. We believe that children and parents of adult recipients, as now provided under title XVI, should be included under title XIX as responsible relatives. In addition, brothers and sisters living in the same home of AFDC and general assistance recipients should be required to provide support according to their ability. If this provision is not changed, the Illinois Department of Public Aid points out that an administrative monstrosity will be created because of the contrast to provisions currently in effect under titles I, IV, X, XIV, and XVI.

Second, we oppose the provision prohibiting a lien upon the property of a recipient. Illinois statutes currently provide that the State may impose a lien upon the real property of recipients of old age, blind, or disability assistance. Inasmuch as the homestead and contiguous real estate of an individual is exempt in determining eligibility for both money payments and medical assistance in Illinois, we believe that the State should not be prohibited from establishing a lien on the real property of recipients mentioned above. The prohibition of the lien provision, in effect, provides for the creation of an estate at public expense.

The third requirement which concerns us would prohibit any durational residence requirement. Under all public assistance programs in Illinois, except the aid to medically indigent aged program under the Kerr-Mills Act, a person must reside in the State for 1 year as one of the conditions for eligibility. We support the 1-year residence requirement, and recommend that item (3) on page 136 of the bill be amended to authorize such a requirement for eligibility for medical assistance under programs covered by title XIX.

In discussions on H.R. 6675 with the Illinois Department of Public Aid, we share their concern that the "maintenance of State effort" formula appears to inject a philosophy into the public aid field that a State has to spend more to get more. We hope the Senate Finance Committee will remedy this situation by adopting the changes we have suggested. It is our understanding that the Illinois Department of Public Aid will recommend revision or clarification of a number of the medical assistance provisions in title XIX that will adversely affect the operation of public assistance programs in Illinois.

COLLECTIVE BARGAINING AGREEMENTS

Your committee has received volumes of testimony on the great expansion of voluntary insurance plans providing medical and hospital care for the aged and it is our belief that this tremendous growth of voluntary insurance makes medicare under social security unnecessary. I do not intend to dwell on that point. However, I wish to express particular concern on the effect the basic plan for providing hospital insurance, etc., under social security could have on existing and future medical and hospital plans for retirees under collective bargaining agreements. It is our firm opinion that the growth and expansion of these programs wherein management and labor determine the types of policies they wish to buy and the benefits they can afford will be discouraged through this medicare program. It is our fear that with possible expansion of the Government's program, increasing employer and employee costs under the compulsory social security tax will discourage employers to enter into new contracts providing these benefits to their retirees.

At present, there are many Illinois-based firms providing both hospital and medical care protection for their retired workers, and I am sure this Illinois experience is representative of the Nation as a whole. I would like to briefly, as an example, relate to you what has happened in my own company.

Through the process of collective bargaining with three international unions, namely, the International Association of Machinists, the International Brotherhood of Electrical Workers, and the International Brotherhood of Boilermakers, as well as one independent union, the Employees' Independent Union, employees retiring under the Wyman-Gordon benefit plan, a voluntary plan, are provided with 365 days of Blue Cross protection, $375 maximum Blue Shield, and major medical expense benefits for the duration of their retirement, at no cost to the pensioner. The same coverage is provided, at no cost, to the wife of the pensioner. At the death of the pensioner, Blue Cross-Blue Shield and major medical benefits are provided the wife until her death or remarriage, and again at no cost. In addition, group life insurance is also provided the pensioner at no cost to him. The same coverages are also provided nonunion employees, retiring under our retirement program.

The pensioners of our fifth union, the International Die Sinkers Conference, are provided with 120 days Blue Cross and $375 maximum Blue Shield coverage, at no cost to them. These same benefits are extended to the wife of the pensioner, and again at no cost to the pensioner.

Frankly, it is difficult for me to forecast what effect the passage of medicare would have on future consideration of expansion of our program. In our situation, the combined employer-employee 1.6 percent social security tax for medicare is an additional unnecessary cost to our company and to our employees.

Senator DOUGLAS. Thank you, Mr. Mann, very much for your very able statement.

On this question of the maintenance of the State effort formula, I think the reason why the Committee on Ways and Means of the House included that was because of the experience we have had on old age assistance. On a number of occasions when we have increased the Federal grants for old age assistance, intending to benefit the aged persons, what we have found has been that the States have diminished their payments to the aged by approximately the same amount as that which the Federal Government has added, and that therefore the Federal expenditures served in these cases not for the benefit of the aged but for the benefit of the states. Therefore, this provision that the States cannot reduce their expenditures below that which they

formerly paid out, was put in, I think, in order to insure that the benefits would go to the aged.

Do you have any comment on that?

Mr. MANN. I might say, Senator, that according to the Illinois public aid people, during 1965—Illinois will spend $82 million, and under the present formula the Federal government will meet only $21 million or 25.7 percent.

For the aged and the blind we plan to spend $44.1 million; for aid to the dependent children, $19.3 million; for the medically indigent aged, $7 million. This is a total of $70.4 million.

On the 50 percent matching we should be entitled to $35 million. However, we are getting $21 million, and we are $14 million short.

Senator DOUGLAS. I am not saying that Illinois has been at fault. But I know that in some States the added Federal grant has been used to diminish the amount of the State payment with the result that the aged are very little better off than before. What has happened is that the Federal Government has assumed part of the burden of the State budget. I take it that the members of the House Ways and Means Committee, believing in local self-government and local responsibility, did not wish to encourage that.

Mr. MANN. I see.

Senator DOUGLAS. On the question of the effect of medicare on previous collective bargaining agreements, don't you suppose you will be able to get a readjustment of the benefits so that with the aid of hospital, nursing homes, home visiting nurse care for the aged largely provided for, and with medical and surgical benefits provided for the aged persons, you will be able to get a readjustment so that instead of duplication of aged benefits these costs can be shifted to greater benefits for those under 65? So there will be not net increase for you, but really a readjustment——

Mr. MANN. Medicare will undoubtedly act as a deductible to our hospital and surgical programs. But the additional costs——

Senator DOUGLAS. And, therefore, diminish the costs to you.

Mr. MANN. Slightly. But the cost of medicare to the employee and the employer in dollars and cents amounts to a great deal of money, which we could use over the years to go out and purchase better—broaden, expand our insurance programs over and above what medicare could possibly give them.

Senator DOUGLAS. That may well be. What I am simply trying to say is that you would either increase your benefits to those over 65 or diminish your contributions for the supplemental benefits under your plan. Protection will be provided under social security rather than under collective bargaining. I have no doubt that you will urge that in your collective bargaining negotiations. I think it would be very hard for a union to resist in all good conscience.

Do you want to make any comment on that?

Mr. MANN. No. I will make no further comment on that, other than to say that our retired employees have the same type of coverage, with the exception of life insurance, that our active employees have, and I think it is perhaps the best and most comprehensive coverage in Cook County. How the retired employees are going to feel about medicare, I don't know.

Senator DOUGLAS. Well, they make no contribution as retired employees to that protection.

Mr. MANN. None whatsover, and I might say, Senator, in addition to the retired employee, his wife is also covered at no cost to him. Upon his death, the Blue Cross and Blue Shield, and major medical catastrophic insurance is given to her at no cost to her until her death or remarriage, which makes it a very attractive package.

Senator DOUGLAS. I think it is very generous, and you are to be commended for agreeing to that provision.

Mr. MANN. Thank you.

Senator DOUGLAS. I simply say if protection under social security is substituted for this, it would seem to me that you could either shift benefits to those under 65 or diminish contributions and, hence, make economies for yourself. We will leave that for the future. In the meantime, think you very much.

Mr. MANN. You are welcome, sir.

Senator DOUGLAS. We will recess this hearing until tomorrow morning at 10 o'clock.

Thank you.

(Whereupon, at 12:40 p.m., the committee was in recess, to reconvene at 10 a.m., Tuesday, May 18, 1965.)

SOCIAL SECURITY

TUESDAY, MAY 18, 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 Abraham Ribicoff presiding.

Present: Senator Ribicoff, Douglas, and Williams.

Also present: Elizabeth B. Springer, chief clerk.

Senator RIBICOFF. The meeting of the Committee on Finance will be in order.

The first witness will be Mr. Hiram R. Hershey.

You may proceed, sir.

STATEMENT OF HIRAM R. HERSHEY, OLD ORDER AMISH COMMITTEE

Mr. HERSHEY. Statement for the Committee on Finance, U.S. Senate, May 18, 1965. Hon. Chairman, honorable members of the committee, ladies, and gentlemen, this appeal is being made in behalf of the Old Order Amish and related church groups in reference to H.R. 6675, section 319, subsection (h), to exempt those conscientiously opposed to participation in social security in any form. [Reading:]

We, as a church body, deeply and sincerely appreciate your efforts to work out a favorable solution to our request for exemption from the old-age and survivors insurance. We prayerfully ask you to consider our plea on the grounds that we have, for hundreds of years, provided for our needy. Our desire to live up to our convictions as our forefathers did compels our plea.

As we feel our beliefs and faith are grounded on the rock, Jesus Christ, against whom the gates of hell shall not prevail (New Testament; Matthew 16:18), it is our Christian duty to look unto God for our protection. To participate in the social security program would, in our opinion, be laying up treasures upon earth, contrary to our Lord's teachings (New Testament; Matthew 16:19–34) and would not preserve God's blessing in our church.

During the past several years various meetings have been held among the Old Order Amish regarding social security with most of the 19 States represented in which our people live. Bishops, ministers, and laymen were present each time. At each meeting a prayer for our Government was offered to God because we believe it our Christian duty to pray for those who have dominion over us. In article XIII of our confession of faith, it states:

"We also believe and confess that God has instituted civil government, for the punishment of the wicked and the protection of the pious. And also, to preserve its subjects in good order and under good regulations. Wherefore, we are not permitted to despise, blaspheme, or resist the same, but are to acknowledge it as a minister of God and be subject and obedient in all things that do not militate against the law, will, and commandments of God. We are also to pay it custom, tax, and tribute, thus, giving it what is its due, as Jesus Christ himself

did. That we are also to pray for our government and its welfare, so that we may live under its protection, maintain ourselves, and 'lead a quiet and peaceable life in all godliness and honesty.' And further, that the Lord would recompense them (our rulers) here and in eternity, for all the benefits, liberties, and favors which we enjoy under their laudable administration" (Dortrecht Confession of Apr. 21, 1632; Romans 13:1-7; Titus 3:1, 2; I Peter 2:17; Matthew 17:27, 22:21; I Timothy 2:1, 2.).

We feel that under the rights established in the Constitution of the United States of America, our plea to you is only to preserve our liberties. In the Preamble it is stated, "and secure the blessings of liberty to ourselves and our posterity." It is the grave danger of losing our posterity to the influence of the world that causes our concern over having a part in the social security program.

Could we not as a church group be exempted from this program as we have been exempted from participating in military service? We feel this exemption has been a blessing to our country.

We feel obliged to the Government to pay all our due taxes, but the old-age and survivors insurance is not a tax. We have no licensed insurance. Liability insurance is not tolerated in most Amish communities.

In conclusion, we again ask you to prayerfully consider our plea. We firmly believe in the motto inscribed on all our coins, "In God We Trust," and to assure this trust for our posterity, we ask you to grant us our request.

The preceding statement is part of a resolution written at a meeting held in Burton, Ohio, on August 27, 1964. Sixty-two leaders of the Old Order Amish signed the statement at that time. Respectfully submitted, Hiram R. Hershey, spokesman for the Old Order Amish, Rural Delivery 1, Harleysville, Pa.

I submit for the record a substantiating statement entitled: "Constitutionality of optional exemption of members of a certain religious faith from the social security self-employment tax or optional recovery of the tax paid."

Senator RIBICOFF. Thank you very much, Mr. Hershey.

It will be placed in the record.

(The statement follows:)

THE GENERAL COUNSEL OF THE TREASURY,
Washington, D.C., August 6, 1964.

CONSTITUTIONALITY OF OPTIONAL EXEMPTION OF MEMBERS OF A CERTAIN RELIGIOUS FAITH FROM THE SOCIAL SECURITY SELF-EMPLOYED TAX OR OPTIONAL RECOVERY OF THE TAX PAID

Legislation has been proposed in the present and the previous Congress to provide optional exemption from the social security self-employment tax for "a member or adherent of a recognized religious faith whose established tenets or teachings are such that he cannot in good conscience without violating his faith accept the benefits of insurance," upon a finding by the Secretary of Health, Education, and Welfare that his application for exemption was made in good faith and that the members of such religious faith make adequate provision for elderly members to prevent their becoming public wards.[1] Senators Clark and Scott, among the chief proponents of this legislation, have explained that the faith in question is that of those Amish Mennonites who are known as the plain people or old order Amish who live in relative independence and isolation in rural communities and adhere strictly to many literal biblical injunctions, including reliance on divine providence for their care. The consistency and sincerity of the sect is attested to by the refusal of most of their members to accept social security benefits or pay the self-employment tax.

In the consideration of these bills in Congress the question was raised as to whether the proposed exemption would be constitutional and the views of the Treasury Department were requested. This opinion is in response to that request. Since then, additional legislative proposals, including an alternative proposal of relief for the Amish in the form of tax recovery in place of tax exemption, have been discussed in a joint statement by the Treasury Department and the Department of Health, Education, and Welfare, entitled "Request

[1] S. 294, 88th Cong.; H.R. 10606, 87th Cong., among others.

of the Old Order Amish for Exemption From the Social Security Self-Employment Tax," which was transmitted to interested Members of Congress by a joint letter dated July 20, 1964. In connection with the earlier request, it is also appropriate to consider the constitutionality of these proposals, as well as the constitutionality of the various limitations included, or suggested for inclusion, in the definition of the faith whose members or adherents would be eligible for exemption. The joint statement referred to above reviews the religious tenets and modes of life of these Amish and provides an extended analysis of the social security system and the possible effects of an exemption. I will not, therefore, in this opinion cover any of this factual material. A copy of this joint statement is attached hereto.

CONCLUSION ON TAX EXEMPTION AND TAX RECOVERY

My conclusion, based upon a review of the principles of constitutional law, is that there is no valid constitutional objection to the proposed exemption and that the question of exemption is one of public policy for Congress to determine. After discussion of the grounds for this conclusion I will review in the latter part of this opinion the constitutionality of various proposed additional limitations upon the exemption.

This conclusion concerning tax exemption comprehends any provision by Congress for tax recovery, since tax exemption is the most complete relief that could be given. In the subsequent discussion, therefore, the constitutional conclusions with respect to the requirements of uniformity, of the first amendment, and of due process should be read as also extending to a provision for tax recovery.

Congress and the States have provided for the recovery of taxes in various situations where for reasons of public policy the legislature has determined this to be appropriate. I have found no constitutional challenge of these provisions. For example, 26 U.S.C. 6420 provides for refund of the gasoline taxes paid for gasoline used for farming purposes. A similar provision in the Virginia Code, section 58-715 (Supp. 1964), includes refunds for gasoline used for public or nonsectarian school buses—26 U.S.C. 6418 provides for refund of the Federal tax on sugar manufactured in the United States to those who use such sugar as livestock feed or in the distillation of alcohol.

If members of the designated religious faith were permitted to choose to recover in monthly installments the amount, and only the amount, of the social security taxes they have paid, they would be under a limitation which operated to their disadvantage as compared with other social security taxpayers to whom an indefinite amount of social security recovery would be available in the form of insurance. Consequently, it would seem that no other social security taxpayer would be in a position to claim that the tax recovery allowed to the Amish in any way discriminated against him or added to his tax burden.

1. *The requirement of uniformity.*—The Constitution provides in article I, section 8, clause 1: "The Congress shall have power to lay and collect taxes, duties, imposts, and excises, to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts, and excises shall be uniform throughout the United States * * *." This canon of uniformity has been long established to be a requirement of geographical uniformity only. *Knowlton* v. *Moore* (178 U.S. 41 (1900)); *Brushaber* v. *Union P.R. Co.* (240 U.S. 1 (1916)); *Fernandez* v. *Wiener* (326 U.S. 340 (1945)). Insofar as uniformity may be required as an element of reasonableness under the due process clause, the problems are dealt with in my discussion of the application of that clause.

2. *The first amendment.*—The proposed exemption, if allowed, would represent a determination by Congress that an accommodation of the self-employment tax law to prevent offense to religious scruples against insurance would not be contrary to public policy. The first amendment provides that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof * * *." The question is whether an exemption from the social security tax would be constitutional as an accommodation or mitigation of a general requirement in order to permit the free exercise of a religion or whether it would be an "aid" to the specified religion at the expense of other religions and therefore be an unconstitutional establishment of religion.

It is my conclusion that the proposed exemption would in all probability be held to be a valid accommodation of the general law to permit religious liberty under the free exercise clause. The subsidiary question whether the definition

of the persons exempted may be a reasonable classification under the due process clause is discussed in a subsequent part of this opinion. I base my conclusion on the following decisions of Federal and State courts, particularly the Supreme Court, which interpret the first amendment to permit accommodations to religious beliefs. This discussion will be followed by an analysis of those cases which hold that certain governmental action is a violation of the establishment clause, in order to make clear that this exemption would not be an establishment of religion.

The classic example of the application of the free exercise clause is the series of cases which have upheld congressional exemption of conscientious objectors from military service. The validity of this exemption was first established by the *Selective Draft Law Cases* (245 U.S. 366 (1918)), upholding the exemption in the draft law of members of religious sects "whose tenets prohibited the moral right to engage in war." The Solicitor General had argued (p. 374) that this exemption did not establish such religions but simply aided their free exercise. The court considered that the congressional authority to provide such exemption was so obvious that it need not argue the point (pp. 389–390).

The present Universal Military Training and Service Act enacted June 24, 1948 (ch. 625, 62 Stat. 604), as amended, in section 6(j) (50 U.S.C. app. 456(j)), exempts from combatant training and service in the Armed Forces a person "who by reason of religious training and belief, is conscientiously opposed to participation in war in any form." This exemption continues to be recognized as constitutional under the free exercise clause. *Clark* v. *United States* (236 F. 2d 13 (9th Cir. 1956), cert. denied, 352 U.S. 882 (1956)); *United States* v. *Jakobson*, (325 F. 2d 409 (2d Cir. 1963), cert. granted 32 L.W. 3385, May 5, 1964). Certiorari was granted in the *Jakobson* case and in two other conscientious objector cases,[3] apparently in order to reconcile the conflict between the second and ninth circuits as to whether the statutory definition of "religious training and belief" as being a "belief in a relation to a Supreme Being" may constitutionally be applied to exclude a conscientious objector whose belief is based on humanistic principles. This conflict is one essentially concerned with reasonable classification of an exemption under the due process clause, discussed below. It does not concern the constitutional right of Congress to exempt conscientious objectors under the free exercise clause.

In the *Jakobson* case the second circuit faced the problem whether "making exemption from military service turn on religious training and belief as stated in section 6(j) aids religions, and more particularly religions based on a belief in the existence of God" (p. 414) and thereby conflicts with the holding in *Torcaso* v. *Watkins* (367 U.S. 488 (1961)). There it was determined that Maryland could not require an oath affirming a belief in God as a prerequisite to becoming a notary public. The *Jakobson* court concluded that "the important distinction seems to us to be that, in contrast to Maryland's notary public oath, Congress enacted this statute, *in mitigation* of what we assume to be the constitutionally permissible course of denying exemptions to all objectors, *for the very purpose of protecting 'the free exercise' of religion* by those whose religious beliefs were incompatible with military service which Congress had the right to require" (pp. 414–415). [Emphasis supplied.]

An exemption identical with that in the 1948 military training act was specifically included in section 337(a) of the Immigration and Naturalization Act of June 27, 1952 (ch. 477, 66 Stat. 163, 258, 8 U.S.C. 1448(a)). This statutory exemption followed the decision of the Supreme Court in *Girouard* v. *United States* (328 U.S. 61 (1946)) ruling that the naturalization law need not be, and should not be, interpreted to exclude an alien who would not promise to bear arms because of religious scruples. Justice Douglas, for the majority, reaffirming principles enunciated in earlier dissents by Justices Hughes and Holmes, said, "The struggle for religious liberty has through the centuries been an effort to accommodate the demands of the State to the conscience of the individual" (p. 68).

The general exemption from taxation of religious groups, activities and property is another example of the exercise by legislatures of the constitutional authority to make exemptions to aid in the free exercise of religion, which continues to be upheld against contentions that the exemption operates to estab-

[3] *United States* v. *Seeger* (326 F. 2d 846 (2d Cir. 1964)), and the *Jakobson* case, compared with *Peter* v. *United States* (324 F. 2d 178 (9th Cir. 1963)). The *Peter* case followed *Etcheverry* v. *United States* (320 F. 2d 873 (9th Cir. 1963)) on which certiorari was denied, (375 U.S. 820 (1963)). The influence of the second circuit against the definition is shown in *MacMurray* v. *United States* (330 F. 2d 928 (9th Cir. 1964)).

lish the religions thus benefitted.[3] Under this exemption a unique religious doctrine may make an activity of one religious group exempt as having a religious purpose which would not be exempt when carried on by other groups not holding to that doctrine.[4] The exemption from taxation of religious activities and occupations is incorporated into the Social Security Act itself which provides optional exemptions for ministers, Christian Science practitioners, employees of religious organizations and members of religious orders (26 U.S.C. 1402 (c) and (e) and 3121(b)(8)).

A further illustration of the principle that a legislature may accommodate particular religious beliefs without violating the first amendment is the case of *Zorach* v. *Clauson* (343 U.S. 306 (1952). Here the Supreme Court held that the New York Legislature did not violate the establishment clause by authorizing public schools to release children 1 hour early every week for religious instruction off the school grounds. It said:

"* * * When the State encourages religious instruction or cooperates with religious authorities by adjusting the schedule of public events to sectarian needs, it follows the best of our traditions. For it then respects the religious nature of our people and accommodates the public service to their spiritual needs" (pp. 313–314).

The distinction between *Zorach* and *McCollum* v. *Board of Education* (333 U.S. 203 (1948)), well illustrates the distinction between the 2 first amendment clauses for in *McCollum* the released time plan was held unconstitutional as an establishment of religion as classrooms and the force of the school were used in that plan.

The most important case, for our purposes, is the recent Supreme Court decision in *Sherbert* v. *Verner* (374 U.S. 398 (1963)). In this case the Court required South Carolina to accommodate the requirements of its unemployment compensation law to the religious scruples of an adherent of a particular sect, the Seventh-Day Adventists. In three separate opinions the members of the Court balanced the demands of the free exercise clause against the prohibitions of the establishment clause. The opinion and the concurring opinion determined that the denial of unemployment benefits to a person unavailable for suitable work on Saturdy because, being an Adventist she could not for religious beliefs work on Saturday, was a restriction on the free exercise of her religion and, therefore, unconstitutional. The dissenting opinion contended that the accommodation of Adventists was a question of policy for the legislature and that while the legislature could constitutionally exempt the Adventist from the requirements for eligibility placed upon all other persons the legislature was not required to do so. Consequently, the full court apparently would agree that Congress could constitutionally make an exemption from the general requirements of taxation and compulsory insurance of persons who because of religious scruples are unwilling to accept social security insurance. It is solely the constitutional ability of Congress to make this exemption to which this opinion is addressed.

The reasoning in the *Sherbert* case needs to be examined as it bears upon the power of Congress in this area. The principle of accommodation of a general law to a particular religious scruple is the same in this situation as in *Sherbert* though the facts differ in that in the *Sherbert* case the accommodation was for the purpose of enabling the Adventist to receive welfare benefits and in the Amish situation the accommodation would be for the purpose of exempting the Amish from benefits as well as from taxation for these benefits.

First, the court says that while "the consequences of such a disqualification to religious principles and practices may be only an indirect result of welfare legislation" and that no criminal sanctions compel work on Saturday, the indirect discrimination is nevertheless a burden on the free exercise of the Adventist's religion. It requires her to abandon her religious precept or forego a welfare benefit generally available (pp. 403, 404). In the social security situation the employment tax is supported by civil and criminal sanctions of assessed penalties and fine, imprisonment, and forfeiture, so that the justification for congressional relief is even clearer.

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[3] *Swallow* v. *United States* (325 F. 2d 97 (10th Cir. 1963)); *General Finance Corporation* v. *Archetto* ((R.I. 1961) 176 A. 2d 73), appeal dismissed (369 U.S. 423 (1962)); *Fellowship of Humanity* v. *County of Alameda* (315 P. 2d 394 (Cal. Dist. Ct. App. 1957)); *Lundeberg* v. *County of Alameda* (298 P. 2d 1 (Cal. 1956)), appeal dismissed, *sub nom., Heisey* v. *County of Alameda* (352 U.S. 921 (1956)).

[4] *Golden Rule Church Association* (41 T.C. 719 (1964), (Nonacq. May 19, 1964)).

Secondly, the court points out that while the State may not discriminate invidiously between religions the accommodation required to be allowed to the Adventist would not be discriminatory but rather would remove a discrimination based upon her religion, since the law does not disqualify persons who do not work on Sundays (at 406). An exemption for those sects which cannot in good conscience accept the insurance for which they are taxed would not be an invidious discrimination against other religions which have no such scruple and whose members are therefore able to accept the insurance for which they are taxed.

Thirdly, the court points out that the administrative problems concerned and the possibility of spurious claims do not justify a restriction on the free exercise of religion (at 407).

Then the court concludes (at 409) that its holding does not foster the "establishment" of the Seventh-Day Adventist religion in South Carolina for the extension of unemployment benefits to Adventists is not like the involvement of religions with secular institutions which the establishment clause is designed to forestall as shown in its decision announced the same day, *School District of Abington Township* v. *Schempp* (374 U.S. 203 (June 17, 1963)). In fact the *Sherbert* ruling reversed the State court ruling that allowance for the religious obligation of the Adventist would be an unconstitutional discrimination in her favor. See *Sherbert* v. *Verner* (240 S.C. 286, 125 S.E. 2d 737, 746 (1962)).

In the *Schempp* and its companion case, *Murray* v. *Curlett*, decided with the same opinion, the court found that the States were establishing religion in their public schools by requiring Bible reading and the recitation of prayers therein. These decisions are developments of the prior term's opinion in *Engel* v. *Vitale* (370 U.S. 421 (1962)), holding that the requirement of recitation in the public schools of a State-authored prayer was a violation of the establishment clause which prohibits Government from placing its "power, prestige and financial support * * * behind a particular religious belief" (p. 431). In the *Schempp* case the Court develops the idea that Government must remain "neutral", a term derived from the 5 to 4 decision in *Everson* v. *Board of Education* (330 U.S. 1 (1947)). In its context in the several Establishment cases this term means an inability of the State to use its powers to require religious observances or to use public funds for the support of religious institutions. None of the holdings applies the establishment clause to forbid the granting of an exemption from Government coercion of a secular action to accommodate religious scruples under the free exercise clause. The latter clause is predicated, says the *Schempp* court, on Government coercion which impinges on religious practice (374 U.S. at 223). The distinction between these two historic lines of decisions has permitted the *Schempp* case to be decided consistently with the *Sherbert* case on the same day.

In sum, then, an exemption removes a handicap to the free exercise of a particular religion placed upon it by force of Government; it is not a requirement by the Government that the particular religion be practiced or observed or supported by nonadherents.

The meaning of the *Sherbert* case is made unmistakable in its application by the court in the recent case, *In Re Jenison* (375 U.S. 14 (1963)). Here the court "in the light of *Sherbert* v. *Verner*" vacated the judgment of the Minnesota Supreme Court in *In Re Jenison* (265 Minn. 96, 120 N.W. 2d 515 (1963)). The Minnesota court had held a person selected for jury duty in contempt of court by refusing to serve on the jury because of a religious belief based upon the biblical injunction against judging other persons. The Minnesota court had reasoned that jury duty, being a primary duty of all citizens, was superior to a religious belief deemed by the court contrary to public order, citing *Reynolds* v. *United States* (98 U.S. 145 (1878)), which held that Congress could prohibit polygamy as a violation of the social order.

Since the Supreme Court has now held that Government must accommodate even the highest duties of citizens to sincere religious scruples, it is probable that it would hold that Congress may accommodate the religious scruple against insurance by allowing for such a scruple an optional exemption, or a lesser form of relief, from social security taxation and benefits.

3. *The due process clause.* Under the due process clause of the fifth amendment tax statutes must provide reasonable classifications of the subjects taxed or regulated and reasonable exemptions, if exemptions are provided. But, as has been firmly established by the Supreme Court, particularly in cases up-

holding the various exemptions provided in the Social Security Act and State unemployment compensation acts (*Carmichael* v. *Southern Coal Co.*, 301, U.S. 495 (1937); *Steward Machine Company* v. *Davis*, 301 U.S. 543 (1937); *Helvering* v. *Davis*, 301 U.S. 619 (1937)), the outer bounds of what is a reasonable tax or exemption classification allow a wider play of legislative judgment than many other areas of the law where the "reasonable" standard is applied. In these cases the Court assured legislatures that they had the widest powers of selection and classification in taxing some at one rate, others at another and exempting others altogether, where distinctions were based upon "considerations of policy and practical convenience."

Claims of discriminatory treatment under social security continue to be rejected as not "patently arbitrary," *Flemming* v. *Nestor* (363 U.S. 603, 611 (1960)). Recently, *Smart* v. *United States* (222 F. Supp. 65 (S.D.N.Y. 1963)). upheld a higher tax on (American) employees of the United Nations, as the means employed bore a substantial and logical relation to the objective; and *Leeson* v. *Celebrezze* (225 F. Supp. 527 (E.D.N.Y. 1963)), accepted differences in dependency determination for children of a deceased mother from that for children of a deceased father, based on family support experience. See also *Cape Shore Fish Co.* v. *United States* (330 F. 2d 961 (Ct. Cl. 1964)), and *Abney* v. *Campbell* (206 F. 2d 836 (5th Cir. 1953)), on fishing vessel employment differences and on domestic service differences respectively.

The requirement that exemptions have a reasonable basis applies as well to exemptions based upon religious scruples provided by Congress in conformity with the first amendment. In a nontax area this requirement has been recently reviewed in the second circuit decisions, pending review in the Supreme Court, on the reasonableness of the Selective Service definition of religious training and belief as being confined to belief in a Supreme Being. *United States* v. *Jakobson* (325 F. 2d 409 (2d Cir. 1963)) and *United States* v. *Seeger* (326 F. 2d 846 (2d Cir. 1964)); certiorari granted in both cases (32 L.W. 3385, May 5, 1964). In these cases the court determined that an exemption from bearing arms based on religious belief was a constitutional accommodation of religion, but that a restriction of the definition of religion to a Supreme Being was too narrow in view of its conclusion that a conscience sincerely compelled to refrain from bearing arms because of a "mystical force of 'Godness'" or a "compulsion to follow the paths of 'goodness'" might be religious in nature. (*Seeger*, p. 853). In other words, at least in the second circuit, the exemption on the grounds of religious objection must reach all who have sincere objections which could be interpreted as religious in nature.

In the social security situation, however, a classification may be as limited as circumstances require, as indicated in the *Smart* and other cases, supra.

In fact the Social Security Act and its amendments have characteristically carved out exemptions which are as narrow as required by the sociological facts, including differences among vocations and religious attitudes. Thus, for example, lawyers are covered by the self-employment tax; ministers, including Christian Science practitioners, are optionally covered; but doctors and persons who have taken the vow of poverty as a member of a religious order are completely exempted (26 U.S.C. 1402 (c) and (e), and 42 U.S.C. 411(c) (4) and (5)). When the self-employment tax was passed in 1950 the act excluded the performance of service by a minister of a church or a member of a religious order or by a Christian Science practitioner in the exercise of their callings, in order to avoid impairment of religious liberty (Senate Finance Committee hearings on H.R. 6000, 81st Cong., Jan. 17, 1950, pt. 1, pp. 1 and 3). The exemption was made optional in the 1954 amendment of the act for these classes of persons except the mendicant orders. These exemptions have not been challenged.

The reason for the present proposal to exempt members of religious sects, as such, is solely that they have a religious objection to receiving insurance. Accordingly, a classification of such sects for exemption purposes, with appropriate safeguards, would reach all those whom Congress would have a reasonable ground to exempt and would, therefore, not be arbitrary nor violative of due process.

This conclusion is the basis of the opinion of the staff of the Joint Committee on Internal Revenue Taxation and that of the American Law Division of the Library of Congress provided to Senator Clark under dates of November 9, 1962, and September 19, 1962, respectively. These opinions conclude that the proposed exemption would be constitutional as it would apply to all those who fall within

the classification and that the classification is reasonable (vol. 109, Congressional Record, pp. 463, 464 (1963)). A copy of these opinions as reproduced in the Congressional Record is attached.

Since, therefore, Congress may exempt those members of a religious faith who have scruples against receiving insurance, the next question is what practical safeguards Congress may designate to assure that only those who come within the policy of the exemption obtain the exemption, without imposing arbitrary limitations.

LIMITATIONS ON THE EXEMPTION

The joint statement by the Treasury Department and the Department of Health, Education, and Welfare reviewing the problems created by the proposed exemption for the Amish contains in section 8 suggested additional limitations upon the exemption. These limitations are proposed as possible means to protect the social security system from an unintended extension of exemptions from compulsory insurance which would weaken and dilute it. The extensions of the exemption might occur, according to this joint statement, either through the formation of additional faiths claiming opposition to acceptance of benefits as one of their tenets or through the redefinition by various existing separatist groups of their tenets to include such opposition.

I shall consider each of these proposed additional limitations, designated "a" through "e", to determine whether the limitation may be considered by the courts to be a reasonable classification and consistent with the due process clause. I shall also suggest a limitation, designated "f", which was not among those proposed but which may be found to limit the exemption reasonably and realistically to the groups which Congress intends to accommodate by this exemption.

(a) *An explicit limitation of the exemption to the Old Order Amish*

This limitation would probably be considered arbitrary since the designation of one sect to the exclusion of other sects having the same scruple would be inconsistent with the congressional policy of removing the Government coercion of belief which constitutes the denial of the free exercise of religion. It would also probably constitute an invalid preference of one particular faith over those which were similarly situated. The facts presented to Congress indicate that there may be certain other sects of the Amish and possibly other religious groups who have the same religious scruple which is now being coerced. Furthermore, the exemption of a single named group will be held to be arbitrary [5] unless the relation to the public good is clearly demonstrable.[6]

(b) *Limitation to members of a sect, excluding adherents who are not members*

(c) *Limitation to members of sects who "take care of their own"*

These limitations are being considered together since at least some of the bills before Congress provide that a necessary condition of exemption is a finding by the Secretary of Health, Education, and Welfare that the sect makes provision for its elderly "members." This condition would probably be considered a necessary and proper public policy consideration and, therefore, a reasonable condition upon which to base eligibility for exemption. The purpose of Congress in this legislation would be to assure the fulfillment of the welfare purpose of social security while relaxing that feature of social security which impinges on the free exercise of religion. Moreover, since individuals can seldom guarantee their own future against deprivation and need, it would be reasonable for Congress to provide that to qualify for an exemption a person must be a member of a sect which shares the religious commitment, both with respect to refusing State insurance and providing for that sect's welfare. Consequently, since the sect aspect is essential, it would seem reasonable to limit the qualification for exemption to persons who are members of a qualifying sect. As said by Justices Black and Douglas in *Board of Education* v. *Barnett* (319 U.S. 624, 643 (1943): "No well-ordered society can leave to the individuals an absolute right to make final decisions, unassailable by the State, as to everything they will or will not do."

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[5] *Eyers Woolen Co.* v. *Gilsum*, 84 N.H. 1, 146 Atl. 511 (1929); *Baltimore* v. *Starr Methodist Protestant Church*, 106 Md. 281, 67 Atl. 261 (1907). Cf. *United States* v. *Department of Revenue of Illinois*, 191 F. Supp. 723 (N.D. Ill. 1961) invalidating a retail tax on sales to the Federal but not to the State government.

[6] *Williams* v. *Mayor and City Council of Baltimore*, 289 U.S. 36 (1933).

(d) Limitation to sects which require members to follow the occupation of farming as a matter of religious principle

This limitation, as phrased, would not be appropriate on the basis of the facts given in the joint statement. It is there stated that "most Old Order Amish communities permit members to make their living as self-employed carpenters or masons" (p. 9). The possibility of limiting the exemption to sects which are established in farming communities for religious reasons is suggested and discussed below.

(e) Limitation to religious groups which were established before 1935

Any limitation which designates a cutoff date would generally be less reasonable than one which on its face shows some relationship to the public purpose of the statute. For example, a requirement that the sect shall have demonstrated over a period of years its ability to take care of its own members would probably be more acceptable as a classification. The text of certain of the legislative proposals already contain this principle in that they refer to the sect to be exempted as one which is "established." I would see no reason why the extent or the test of establishment might not be specifically spelled out. There is some authority that a "classification which draws a line in favor of existing businesses as against those later entering the field will be upheld if any reasonable and substantial basis can be found to justify the classification." (*Del Mar Canning Co.* v. *Payne*, 29 Cal. 2d 380, 175 P. 2d 213, 232 (1946)). The circumstances justifying such a discrimination must provide substantial reason (*Mayflower Farms* v. *Ten Eyck*, 297 U.S. 266 (1936)). It is probable that the unusual situation of the Amish with respect to social security would be considered a substantial reason for a limitation of the classification to established sects.

(f) Limitation to sect established in farming communities for religious reasons

The faith, the members of which are to be exempted, might be described not only as one whose established tenets would be violated by the acceptance of insurance, and one which provides for elderly and dependent members, but as one which for religious reasons is established in farming communities. These limitations might be reasonable if Congress found after sufficient inquiry that they were necessary to assure that the exemption would be confined to sects which were religiously motivated and responsible, and to assure that the welfare purpose of social security would be fulfilled. Congress might reasonably find that the restriction of the exemption to those sects established in farming communities would be justified on the ground that such a sect could be more certainly relied upon to identify and provide for its dependent and elderly members than those in the mobile and transient urban environment. Conversely, the limitation would have the effect of excluding sects which subsequently organize for the purpose of exemption from social security, as it is unlikely that these would or could establish themselves in farming communities for religious or other reasons. The limitation would exclude other present separatist groups whose principles might, but do not specifically, include refusal of social security benefits. Legislation which distinguishes farming situations from others because of sociological and economic differences has taken many forms and has been accepted by the courts. (See, e.g., *Tigner* v. *Texas*, 310 U.S. 141 (1940), rehearing denied, 310 U.W. 659 (1940).)

G. D'ANDELOT BELIN,
General Counsel.

Senator RIBICOFF. Mr. George McLain.

STATEMENT OF GEORGE McLAIN, CHAIRMAN, NATIONAL AND CALIFORNIA LEAGUE OF SENIOR CITIZENS

Mr. MCLAIN. Senator Ribicoff, my name is George McLain, with headquarters at 1031 South Grand Avenue, Los Angeles, Calif.

For the past 25 years I have represented the elderly, the blind, and the physically disabled, primarily those on public assistance, both before the National as well as the California State Legislatures. I am here today representing our membership or myself for the purpose

of endorsing H.R. 6675, otherwise known as the Social Security Amendments of 1965, and to urge further amendments.

Congress is engaged in appropriating and spending many millions of dollars toward solving the great problem of poverty that affects so many of the American people of all ages. Because of my many years of experience with recipients of social security as well as public assistance, I know the hard core of poverty can be solved by Congress through our social security system. I wish to make some recommendations for amendments to H.R. 6675 which we believe to be not only most timely, but far reaching in their beneficial effect.

Funds for the contributory section of the Social Security Act can be raised by an increase in the tax base as advocated by the Advisory Council on Social Security; and increases in the noncontributory section, from the general fund.

We urge an across-the-board increase in social security payments of $7 a month, hiking the minimum payment from the present $40 to $47 as approved by the Senate last year.

While H.R. 6675 provides a $35 a month social security payment to men and women 72 years of age and over who have worked a total of 9 months under coverage, it will mean little to the majority of these people as they have long ago lost their social security cards or have forgotten their social security number, even the names and the places they worked under covered employment. Many of these people are recipients of public assistance, and this will present a considerable problem to the States in seeking to qualify them for this coverage offered by Congress. It would afford considerable monetary relief to the States, as well as administrative savings in time and effort, if your committee would offer this coverage to men and women 72 years of age and over, proof of age being the only requirement.

It is most gratifying to note H.R. 6675 provides that social security payments be made available to widows at age 60 years. It can be anticipated that the great majority applying for these payments will be in desperate need. Surely Congress in its wisdom and compassion, can see the necessity of augmenting this meager income by lowering the age widows can apply for public assistance to age 60.

It is extremely doubtful that any of our 50 States have similar laws on what constitutes a needy person, and this person's qualifications to receive public assistance. Congress should act now to bring about more uniformity by authorizing the Department of Health, Education, and Welfare to establish a floor under what constitutes a needy person; that the present 5 year residence requirement established by Congress be scaled downward during the next few years to 1 year.

Because of the mounting cost of dual administration by the State, towns, and counties (California's State and 58 county duplication of administration has mounted to over $82 million a year for administrative costs alone), the time has come for Congress to insist upon an efficient single State administration by amending H.R. 6675 to "provide for the establishment or designation of a single State agency to administer the plan."

H.R. 6675 thoughtfully provides that the States may disregard so much of the OASDI benefit increase (including the children in school after 18 modification) as is attributable to its retroactive effective date. My experience with the State's habit of pocketing in their

general treasury increases voted by Congress for public assistance (70 percent of California's adult caseload are also recipients of OASDI benefits) compels me to earnestly request that this provision be made mandatory instead of permissive by inserting "shall" instead of "may." This small amount, estimated by me at an average of $35 per recipient, would mean a real windfall to them.

The public assistance increase put in last year's bill through the efforts of an esteemed member of your committee, Senator Russell Long, would have been effective October 1964. These needy people cannot understand why they are being penalized in H.R. 6675 by having this small payment delayed to January 1966. We hopefully pray that the Senate will make this increase effective for the needy in October 1965.

It is becoming extremely difficult to obtain additional much-needed increases in public assistance in the high per capita income States. We regret to note that H.R. 6675, while providing for a greater share of Federal matching of funds, continues to penalize those—

States whose per capita income is above the national average, shall receive correspondingly lower percentage but not less than 50 percent.

We recommend these States also be permitted to receive 55 percent Federal matching, and we believe the time has come when the unrealistic ceiling imposed upon Federal matching be eliminated entirely. Certainly these 30 years the Social Security Act has been in effect has proven that the States will not be overly generous to their needy on public assistance. Yet this ceiling penalizes the States who desire to be considerate of their poor.

It is noted that H.R. 6675 contains a number of provisions to bring about a little more uniformity among States. Unfortunately, these new provisions are limited to the medical assistance program. We urgently request that the same provisions be provided through the money payments. For instance, the requirement that—

States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child, or children over 21 who are blind or permanently or totally disabled.

And that the—

States may not impose a lien against the property of any individual prior to his death on account of (medical) assistance payments, except pursuant to a court judgment concerning incorrect payments, and prohibits adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death, and that of his surviving spouse * * * Such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

There are a number of long sought provisions contained in H.R. 6675 which, unfortunately, are limited to the medical assistance program and should be extended to that section dealing with the money payments for those on public assistance. H.R. 6675 provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans, and of his action under such programs or noncompliance with State plan conditions in the Federal law.

I view this provision with a great deal of alarm, as the district attorneys of California's 58 counties have sought such a provision for many years in their attempts to block, in the courts, humane public

assistance amendments adopted from time to time by Congress and the State legislature. I am afraid that this provision will bring about much delay and deprive the needy of congressional benefits. I can recall sitting in the audience several years ago when a representative of the California County Supervisors Association urged the adoption of a similar judicial review provision and was severely reprimanded by the late Senator Robert Kerr of Oklahoma, who was acting as chairman pro tem of this committee. I trust you gentlemen will reconsider this provision.

It has been found where a recipient of old-age assistance with a wife too young to qualify and unable to get relief of any kind is penalized because they both share one household and his aid is reduced. If he left his wife and lived alone his full amount of aid would be restored. In order to correct such a situation, which I have found to be quite common, I wish to recommend the following:

Assistance furnished to an individual under this title is to assist him in meeting his individual needs, and is not for the benefit of any other person; and such assistance shall not be regarded as income of any person other than such individual.

In 1935 Congress recognized the wisdom of providing for money instead of vendor payments in the public assistance section. However, now that Congress has provided housing for the elderly, it has been found that the owners of such housing are reluctant to rent to those on public assistance because of the undependency of their income. The California League of Senior Citizens is the sponsor of one of the largest quality, low-rent housing for the elderly projects in Fresno, Calif. We cater to the low income group, especially those on public assistance. Unfortunately, we have found some of these people failing to pay their rent, even though it was allowed them by the welfare department. In our 3 years of operation the village has lost $2,600 on nonpayment of rent by public assistance recipients. This is difficult for a nonprofit corporation to absorb, and represents a considerable loss. In order to avert future losses and encourage similar nonprofit owners to take in public assistance recipients, we recommend the following amendment to H.R. 6675:

To the extent provided by the State agency, direct rent payments to the landlord or landlords involved on behalf of individuals who are otherwise eligible for assistance under the State plan approved under this title, if the dwelling accommodation with respect to which such rent payments are applicable (or the structure in which such accommodations is located) was purchased, constructed, or rehabilitated, or is otherwise being financed, by means of a loan, mortgage insurance, guarantee, or other form of assistance by an agency of the Federal Government which is still outstanding at the time such payments are made; and any such payments shall be considered money payments made to such individuals.

I trust the recommendations I have made from my 25 years of experience with those on the receiving end of social security and public assistance will receive consideration from the members of this committee, and I wish to thank you for giving me this opportunity to express my views.

Senator RIBICOFF. Thank you very much, Mr. McLain.

Mr. Arthur J. Packard.

STATEMENT OF ARTHUR J. PACKARD, PRESIDENT, PACKARD HOTEL CO., CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE, AMERICAN HOTEL & MOTEL ASSOCIATION

Mr. PACKARD. Good morning, Senator.

For the record I am Arthur J. Packard, president of the Packard Hotel Co., with headquarters in Mount Vernon, Ohio. I am chairman of the Governmental Affairs Committee of the American Hotel & Motel Association. I am also president of a chain of small hotels and motels in Ohio.

We appreciate the opportunity to discuss with this committee section 313 of H.R. 6675. This section in the bill has created nationwide concern in the innkeeping business.

We have never objected to paying our share of the social security tax on payroll. The point is, however, that tips received directly by an employee are not and should not be considered payroll for tax purposes.

Neither in theory nor in practice can we justify an arrangement between two separate parties who have nothing to do with an employer's payroll, but which imposes a Federal tax on an entirely separate party, namely, the employer.

In our opinion, tips are a hybrid or in the twilight source of income and should be considered as being closest to self-employment earnings. We must also recognize that tips cannot be considered purely a wage because after all the employer does not exactly determine the actual amount that the employee received.

We must object to a proposed law which would require an employer to accept an employee's statement as to the amount of tips he received. This is tantamount to asking an employer to incur a responsibility which he cannot budget and to pay taxes on a base of which he has no accurate knowledge and over which he has no control. The employer cannot rely on a tip declaration given him in 1 month to aid him for the purposes of tax in the next month.

A hotel-motel employer has no more knowledge of what his employee receives in total tip income than you or I know as to how much a minister of the gospel gets in "gratuities" over a year's period; than a shoeshine boy receives "in tips" in a day; than a barber receives "in gratuities" in a week's time; or that a taxicab driver receives "in tips" in a period of an hour. It just doesn't seem right under these circumstances to place an employer in a position of accepting a statement of tips received from an employee and at the same time require the employer to accept such a declaration as gospel. Actually, the employer has no way of knowing whether or not the employee's report is authentic.

Under the terms of H.R. 6675 a hotel employer or manager may be put in the untenable position of filing a tax return which contains information which he knows to be incorrect and which is in effect implementing a fraud perpetrated on the Government by an employee.

For example, in most hotels there are occasions when the management has exact information as to certain tips being received by the employees. It has become a common practice for patrons having charge accounts at hotels to indicate on the food or beverage check the amount of a tip to be advanced to the employee by the hotel. When

this is done by individual patrons, the employer is not required to withhold income tax or social security on the amount of such tips. However, the management thus knows that the employee is receiving at least this amount of tip income. The employer might know that a particular employee received exactly $42 in tips during a specific month under this system. At the end of the month the employee declares that his tip income for reporting purposes was only $30 and, under this bill, the hotel employer or manager has no choice but to accept the employee's report and base the employer's social security and income tax withholding returns upon the report although he knows that the employee is defrauding the Government to that extent.

Another similar situation arises where a banquet is held by an organization which arranges with the hotel to add 15 percent to the bill, which is then distributed to the employees as gratuities. Under the present Treasury regulations, the hotel is required to withhold income tax and social security on such tips. To this extent the hotel knows exactly how much each employee received in tips. If the amount subsequently reported for the month under the provisions of H.R. 6675 is less than the amount so distributed, the hotel is in a quandary. It has already withheld income tax and social security on these tips but under the present bill it is required to withhold only the amount reported which might be substantially less.

If the provisions of the bill supersede the present withholding requirements, the hotel may again become a party to a fraudulent report by the employee. These two examples illustrate the impossibility of writing a law and imposing a tax based upon a voluntary statement by an employe to an employer.

Regardless of the consequence, even if the employee is convicted of a willful fraud on the U.S. Government and the manager is held immune from prosecution, we in all honesty do not think such a requirement in the law is fair to the reputation of a hotel employer or manager, to his family, or to his standing in the community.

The language in section 313 of the bill actually does violence to commonsense. There is no question that tips are clearly "income" for tax purposes. They are a gratuity, however, paid by a patron, not by an employer. The language of the bill is unjust and unfair when it states on page 222 that—

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.

Can an assumption contrary to fact be made the basis of a tax?

The bill will require that separate records be maintained for each tip employee, even those who are maintained on a temporary basis such as extra waiters. These extras or "casual employees" are oftentimes here today and gone tomorrow. It appears from the bill that if extra waiters are engaged in a given month and the total tips that they receive while working for several employers exceed $20 in each case the waiters would have to furnish each employer with a declaration of tips for that month. Just think of the records an employee must keep. He must keep a daily record of every place he works, and when during a given month has has received $20 in tips, he must make a report of such tips to the employer involved. We, frankly, do not

know how the social security tax would be worked out for an extra waiter working for several employers during a month. It certainly would be improper, small as the amount might be, to impose a social security tax on an employer (disliked by an employee) for tips earned during the course of any employment by another—and yet, this is entirely possible.

The numerous casual or extra employees in our industry create an additional inequity.

For example, two or more employers may each pay the social security tax on the present base of $4,800 or on $5,600 under the terms of the bill for the same employee. Each employer would also deduct that employee's tax from his wages. The employee, however, through his income tax return can recover any excess that has been deducted from his wages over and beyond the ceiling of $4,800 now, $5,600 in the proposed law. Not so for the unfortunate employer. There is no recovery provisions for any employer. Each one of the two or more employers will be forced to pay a tax up to the $5,600 ceiling on that one employee.

Whether a waiter is a permanent or extra employee, it is likely that in many cases the withholding tax on tips would exceed the amount of cash wages due. The untenable nature of the employer's position is apparent. The employee would receive a tax receipt instead of a cash wage. The detriment to the employer-employee relation is clear on its very face. You can imagine what will happen when an employee who obtains substantial income from tips finds out that he is no longer entitled to his regular wage for a certain payroll period because his share of the social security tax plus withholding has reduced it to zero.

The problem will be even more difficult if the employee does not have sufficient wages or other funds made available to the employer to cover his tax on his declaration. Take the employee who has little or no regular wages but relies solely on tips. As he files one or more monthly written statements of tipped income, as he could do under the bill, and fails either by design or accident to provide sufficient funds to cover withholding or the social security tax, the employer is placed in an awkward and extremely difficult position.

We firmly believe that section 313, if enacted, will create tremendous discord in employee-employer relations.

Our contention that an employer will be faced with paying a tax at the whim and fancy of an employee finds support in the fact that a young worker or a female contemplating early marriage and retirement from the labor force will be inclined to report little if any tip income. However, those employees approaching retirement will be inclined to declare substantial tip income so as to obtain maximum benefits under the social security system.

Moreover, an employee who in one month has suffered a serious illness in his family or has added expense in his household, or a bad day at the races, could very easily declare a minimum tip income. The next month with reduced household expenditures or a good day at the races, he could double or triple the amount of tip income to his employer.

We dislike both the social security tax and withholding provisions. However, even if the withholding provision were deleted, we would still not be sure of the employer's liability to withhold taxes on tip income. The reason for this is that section 3403 of the Internal Revenue Code specifically makes the employer liable for withholding taxes on wages. Under this section, if an employer requires an accounting from an employee for tips, these may become wages for all purposes and the employer is required to withhold on them or face liability for payment himself.

Query: If the withholding provision in section 313 is deleted, would the language of that section still indirectly require the withholding of income taxes based on tipped income?

We are convinced that if a tax on tips is to be imposed for social security purposes, the most practical, beneficial, and least complicated way of handling the matter is to consider such tips as true self-employment income. This would avoid disputes between employer and employees, avoid disputes between unions, and put the employees on their own to pay taxes and to receive benefits based on the taxes that they pay.

There would be no difficulty in the computation of tax. The employer would pay his share of the social security tax on the employee's regular wages. Annually, the employee would declare his tips as self-employment income. The employee's tax on self-employment income for social security purposes would only apply to the extent that regular wages did not reach the required dollar base per year.

Testimony before the House Committee on Ways and Means indicates that the major objection to considering tip income as self-employment income is "dilution" of the system. As one of the Government witnesses testified, however, the reason Congress originally adopted the self-employment approach is that the age of retirement is generally later for the self-employed. Congress felt that the delay in retirement would partially or totally offset the fact that the self-employed annually contribute one-quarter less to the system than the combined employer-employee contribution. This reasoning is particularly applicable to the situation as its exists in the lodging industry, for perhaps in no other industry are there a greater number of employees working beyond the normal retirement age. The reason for this is that employees in the innkeeping industry have pride in their position as "server of the public" and more often than not, as a matter of choice, work well into their latter years.

We firmly believe that the amount of tip income that an employee receives from a third party should be a matter between him and his Government. Nothing can be gained and only discord and confusion can follow by attempting to make an employer a "middleman" between a hostile tip employee and his Government.

Senator WILLIAMS. Thank you, Mr. Packard. You have raised some excellent points here which I am sure will be considered by the committee.

Mr. PACKARD. Thank you, Senator Williams.

Senator WILLIAMS. The next witness is Mr. Leslie Scott, representing the National Restaurant Association.

STATEMENT OF LESLIE W. SCOTT, DIRECTOR, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL RESTAURANT ASSOCIATION

Mr. SCOTT. Thank you, Mr. Chairman.

My name is Leslie Scott. I am president of Fred Harvey, Inc., a corporation with headquarters in Chicago, and I am appearing this morning for the National Restaurant Association of which I am a director and a member and past chairman of the Government affairs committee. I am also representing the American Motor Hotel Association, a trade association affiliated with the National Restaurant Association. Mr. S. Cooper Dawson, Jr., a past president and chairman of the governmental affairs committee of the American Motor Hotel Association will file a statement for inclusion in the record. I am accompanied here this morning by Mr. J. W. Putsch, of Kansas City, the chairman of our government affairs committee, and by our Washington counsel, Rear Adm. Ira H. Nunn.

The National Restaurant Association is the trade association of the food service industry. Through direct membership and affiliation with 135 State and local restaurant associations, it represents over 100,000 restaurants in the United States.

I am, as I have stated, now associated with the restaurant industry as president of Fred Harvey, Inc. Prior to that, I served for 10 years as a member of the faculty of Michigan State University as director of the School of Hotel and Restaurant Management, as assistant dean of the College of Business, and as director of continuing education. I am also a member of the Committee on Ethics of the National Collegiate Athletic Association.

The National Restaurant Association and the restaurant industry are not opposed to having tips count for social security purposes. On the contrary, we think that tips should count for all purposes; for social security, for income tax, and as a credit against wage requirements should the Fair Labor Standards Act be extended to cover our industry.

Tips constitute a very substantial part of the total income of many of the employees of our industry. It would be unfair and unreasonable to fail to recognize this. It would be equally unfair and unreasonable, however, to give recognition to tip income by treating tips as wages.

Tips are not really wages. The employer provides the surroundings and circumstances from which tips result, but he in no way participates in the tip transaction. He cannot control the amount of the tip. Actually, he is powerless to prevent tipping. Tips are unique. They are at best a hybrid form of income but most nearly like self-employment income. The tip employee is in effect a concessionaire. He is paid wages by his employer for doing his work. He receives tips from customers for doing his work well.

The National Restaurant Association agrees that tips should count for social security. We hope to show that the only reasonable, practical, and equitable way to provide social security benefits and protection is to treat tip income as "other" income—the self-employment

Section 313 of H.R. 6675 requires employees who receive tips to report to their employers in writing, at regular intervals, the total amount of their actual tip income for the period covered. We would

expect these reports to be required on a weekly basis. The employer would have to withhold the Federal income and social security taxes due on the tip income from the wages of the employee. He would have to accept cash payments from his employees to cover these taxes if wages were insufficient to do so, but he could not withhold the tax on tips from any tips which might come into the employer's possession. Also, the employer would have to match the social security tax contribution of his employees.

Section 313 treats tips entirely as wages. We think this is not the proper approach. Treating tips purely as wages would create many problems and cause many hardships to restaurant employers.

Employees will resent having to report their tips to their employers. Most waiters and waitresses will not discuss their tips with anyone. Tips are never discussed or disclosed. The employee feels that the tips he receives arise from his personal relationship with his customer. To the waiter, that makes them his business and not that of his employer.

Many tipped employees feel that their employer has an adverse and hostile interest in their tip income. They feel that if they disclose their tips to the employer he would attempt to lower wages.

This fear of lower wages will in many cases result in the Government's receiving less income tax from tipped employees. Many employees will be reluctant to report truthfully for fear of having the double penalty of high taxes and lower wages.

Another morale problem would come from the fact that certain stations in most restaurants for one reason or another are better tip areas than others. The employees who have good tip stations now do not reveal their tips, but should tips be reported to employers, the employer will face the problem posed by employees vying for the choice spots.

The restaurant industry is completely dependent upon high morale and the continued good will of it speople. The waiter or waitress is the sales person of our industry. If they are required to report their tips to us, morale will suffer. Since our industry depends on continued good will for its success, business, too, will suffer if section 313 is enacted.

Most tip employees would notice a significant drop in takehome pay if section 313 is enacted into law. For most, it will mean about double the amount of taxes now with held. A person with weekly wages and tips of $40 each now has $5.35 withheld. His weekly withholdings would go to $12.98 next year if tax on tips is enacted, and withholdings on tips is done weekly. This is more than double the amount now withheld. This does not consider State income tax, union dues checkoff, insurance or other customary deductions such as payroll savings for purchase of U.S. Government bonds, and profit-sharing plans.

And even more importantly and dramatically, relations will suffer because in the not at all unusual case, the employee will get no paycheck at all, but a tax receipt instead.

A waitress could work 48 hours a week at $0.75 an hour and receive $5 a day in tips. This is a low figure, but if she were to pay her month's income and social security taxes out of one paycheck, she would be left with but $15.44 for her other deductions and herself.

However, if her tips averaged $10 per day she would get a Federal tax bill of $7.50 instead of a paycheck.

Even if the taxes were withheld weekly, there would be difficulties. Consider the case of a waiter with basic hourly wages of $0.87 receiving $4 an hour in tips and receiving $1.25 per day in meals while at work. He would have a wage due at the end of the week of $34.80 but his Federal tax bill alone would be $33.25. Thus, his paycheck next year even without other deductions could be no more than $1.55. As the social security tax rate goes up, even this small amount would be absorbed by the Federal taxes due.

The paycheck suffers so heavy a blow because section 313 makes tips the measure for withholding without the tip fund being available for withholding. Everything must come out of the paycheck.

Now, on pay day, the employee does not think of all he has made in tips. He realizes only that his paycheck has been drastically cut. He feels he has worked for next to nothing. Thus, morale suffers further.

The result of the lowered paycheck would be that employees would expect and demand that employers make up the difference, and soon, in effect, employers would be paying all of the tax.

Even without pressure for higher wages, section 313 would be very expensive to an industry with an already poor profit picture.

The tremendous bookkeeping burdens that would be imposed would be very expensive from the standpoint of time and personnel. Extra clerical personnel would have to be hired. The fluctuating nature of tip income would make it impossible for most large operators to continue the use of automated payroll systems. The provision of section 313 permitting estimates of tip income would not materially help because adjustments would have to be made to tips actually reported. Also, we do not know enough about tips accurately to estimate their amount for any given quarters.

The tax burden itself is considerable. Using now, figures from the Census Bureau, the annual estimated total sales in restaurants where tips are customarily received is $11.6 billion. Estimating tips at 15 percent of sales, and using 5-percent payments by the employer, the annual additional cost to the restaurant industry would be $88.4 million.

Now, using figures from the Internal Revenue Service, we find an annual estimated profit of $676.1 million in establishments in which tips are customarily received. Thus, enactment of section 313 would wipe out 13.1 percent of the profit in food service establishments where there is tipping.

This loss of profit would occur before we estimate the increased costs and burdens of bookkeeping, recordkeeping, and the additional personnel or overtime required to do the job.

Unlike all other costs of doing business, the employer would have absolutely no control over the tremendous costs imposed upon him by section 313. Enactment of section 313 would for the first time introduce into our law the requirement that an employer withhold and pay based on funds (tips) over which he has neither custody, possession, nor control, and of which he does not even have knowledge of the amount.

Employers would be entirely at the mercy of their employees as to the amount of tips reported. They would have no right to question the accuracy of the tip reports. Employees could report low when young or when not interested in social security or the payment of taxes. They could report high when approaching retirement in an effort to increase ultimate benefit payments. There would be no guarantee of accurate tip reporting. Bear in mind that many waiters and waitresses are young persons—students in many cases—and young married women who regard their work as temporary and do not expect to build up social security equities except as spouses.

Many restaurateurs when explaining the provisions of section 313 to their employees have found these employees quite concerned about it. Many tip employees have written their Senators and Congressmen to urge the elimination of the tips provision from the medicare bill.

Even within the union ranks there has not been uniformity of support for the treatment of tips as wages for social security and income tax purposes.

At the 34th General Convention of the Hotel and Restaurant Employees and Bartenders International Union held in Chicago April 22-27, 1957, the convention considered a Resolution No. 60 which was submitted by local No. 17 of Los Angeles. In this resolution, the members of Waiters Union Local No. 17 of Los Angeles expressed grave concern with a proposal supported by some affiliates of the International Union to institute legislation which would require tipped employees to report their gratuities to their employers. The purpose of this proposal was stated to be the provision of a basis for obtaining maximum social security coverage. The resolution expressed sympathy with the objective of the proposal, but resolved, among other things, to appeal to the convention to oppose and reject any resolution advocating the declaration of gratuities to employers.

Resolution No. 60 was adopted with certain amendments not pertinent here, and Resolution No. 66, which would urge "amendment of the social security law so as to include gratuities in income reported for social security taxation and benefits according to a formula that can be adapted to the conditions in each State" was not adopted by the same convention.

During debate on Resolution No. 60, Mrs. Jackie Walsh of local No. 48 in San Francisco, a waitress local supported Resolution No. 69 and opposed the reporting of tips to employers for a number of reasons, and she said:

> I certainly wish that there were a way to have the law amended—the social security law—which would grant the right to employees to have gratuities considered as any other income other than wages at the end of the year, just as a self-employed person or someone who has a small business is allowed to do, and they then could include in their social security benefits the tax payment allowed with the greater right than for the greater social security benefits.

Thus, employees and union leaders of the restaurant industry are not solidly behind section 313. This bill would not apply to restaurants only, however. It would affect bellmen, barbers, beauticians, parking lot attendants, doormen, redcaps, and many others in many industries. Even the Congress has tip employees in the barbershops and perhaps elsewhere. Many members of these other tip groups and their employees oppose section 313.

Mrs. Walsh's contention was that the ideal situation would be to treat tips as self-employment income. This is the National Restaurant Association's position as well.

The banquet waiter whose tip is charged as part of the bill gets social security protection based on his tip income as well as his wages. However, in this case, the employer actually knows the true amount of the tip because he charges for the tip, collects the tip, and pays the tip over to this waiter.

In this case the employer has knowledge of and control of the tip. He even takes custody of the tip moneys. None of this would be possible under section 313 and without such control the employer would be completely subject to his employees' wishes.

Another way to base social security benefits on tip income as well as wages is reflected in a contract now in effect between the Hotel Association of New York City, Inc., and the New York Hotel Trade Council AFL-CIO. Approved after an appeal by the Social Security Administration, effective June 1, 1963, it provides among other things that—

> * * * all tipped employees except those in banquet departments shall be deemed, for each weekly payroll period after said date, to have certified and accounted to their respective employers for an amount of gratuities that they have received which amount when added to their weekly gross salary shall equal $70; and the respective employer shall pay and make deductions for Federal social security tax purposes based upon such sum of $70 per week for each of these employees.

Still a third way to reach this objective under existing law is by agreement between employer and employee. Under such an agreement, accurate accounting to the employer is required. This method is much like section 313 except that it is based on voluntariness. It is little used in the restaurant industry, an indication that neither employers nor employees in our industry want it.

The National Restaurant Association wants tips to count for all purposes. We share the desires of the union leaders to provide social security protection based on tip income as well as wages. We disagree with their contention that tips should be treated as wages. We submit that tips are other income and more nearly like self-employment income.

Tips are unique, a hybrid sort of income. The Social Security Administration has difficulty finding the waiter to be engaged in a trade or business, a requirement for the self-employment approach. It is unfortunate that our law has been narrowed down to but two concepts in this area: wages and self-employment income. True, the waiter is not completely self-employed, an independent contractor, because he does work at our direction and under our control.

However, insofar as his tip income is concerned, it possesses more indicia of self-employment income than of wages. It is truly the product of his personal effort. True, he has no real capital investment in his trade or business but then neither does a court reporter.

Existing law concerning social security coverage of court reporters is worthy of our attention because the analogy to the waiter is quite close insofar as the sale of transcripts is concerned. The employer of the State or municipal court reporter withholds from his salary or wage both income and social security taxes. This is like the waiter

with his basic wage. Now the court reporter is allowed to sell transcripts to the public and this is like the waiter who receives tips from his customers. The court reporter makes his own returns on his income from the sale of transcripts and pays such taxes as may be due if he were self-employed. The waiter should do likewise in the case of tip income. Indeed he does so now in the case of income taxes.

Treating tips as self-employment income would not be expensive to waiters and waitresses. The annual cost of this approach to a waiter working 40 hours per week and averaging $1 per hour in tips would be $45.24. This is less than $1 per week. For this he would be relieved of reporting to his employer and his social security benefits would be identical with what he would receive under section 313.

Tips are not wages. Tip income is another kind of income. Tips are really like dividends on stock or rentals from leases of property or interest on a savings account. It was proposed to the Congress in 1962 that dividends, rentals, and interest be withheld upon for income tax purposes. This was rejected by the Congress in the Revenue Act of 1962 because such other income was not reasonably related to wages or the employment relationship and because the scheme was unwieldy and unworkable. The same is true of the proposals of section 313.

We believe that tip income is such other income as to be self-employment income and should be so recognized and treated for social security and Federal income tax purposes. We submit that the self-employment approach provides the only reasonable, practical, and equitable solution; fair to the employer and employee alike, to the problem of basing social security benefits on tip income. If the committee does not agree to this formula and approach to the problem, we urge that section 313 be eliminated from the bill as unworkable and unduly burdensome upon employer and employee alike.

There are solutions for this problem under existing law. This being true, it would be a great pity to deprive a great industry of 13 percent of its profit when the law now provides adequate remedies.

Thank you, Mr. Chairman.

Senator RIBICOFF. Thank you very much, Mr. Scott.

Miss Julia Algase.

STATEMENT OF JULIA ALGASE, LEGISLATIVE COUNSEL, REPRESENTING NEW YORK HOTEL & MOTEL TRADES COUNCIL, AFL-CIO; ACCOMPANIED BY E. SARNI ZUCCA, SECRETARY, DINING ROOM EMPLOYEES UNION, LOCAL 1; VANGEL KAMARAS, CHAIRMAN, SOCIAL SECURITY AND TIP COMMITTEE, HOTEL TRADES COUNCIL; AND FRED FERRARA, PRESIDENT, LOCAL 11, DINING ROOM EMPLOYEES

Miss ALGASE. My name is Julia Algase. I am the legislative counsel and assistant to Mr. Jay Rubin, the president of the New York Hotel & Motel Trades Council which was just referred to in the statement preceding mine.

The council represents 35,000 hotel and motel workers in New York City under collective bargaining agreement with the Hotel Association of the City of New York.

Present with me today is Mr. Vangel Kamaras, a vice president of local 6, one of our constituent unions, and chairman of the Social Security and Tip Committee of the Hotel Trades Council, as well as other representatives, who are a la carte waiters in the New York City hotels representing the large number of tip workers that we represent among the 30,000. The tip employees we represent are waiters, waitresses, bellmen, baggagemen, and doormen.

I would like to add in addition, Senator Ribicoff, if I may, that on my right is Mr. Sarni Zucca, the secretary of the Dining Room Employees Union, Local 1 in New York City.

On my left is Mr. Fred Ferrara, who is the president of Local 11 of Dining Room Workers.

Yesterday I was present when Mr. Cyrus Anderson, for the Hotel & Restaurant Employees International Union presented in advance the answers to the arguments that he anticipated from both the hotel association, the American Hotel Association, and the Restaurant Association.

We come here to ask you to retain intact section 313 of H.R. 6675, the section which defines tips and wages and provides a reporting method for that purpose. As you have heard this proposal has been opposed by the American Hotel Association and by the Restaurant Association. We are told as excuse for opposition either that the program will be difficult to administer or that the employees involved do not want the coverage.

For instance, you were told this morning that Miss Jackie Walsh of California local said way back in 1957 that she wished there were a way of covering it. Our employer opposition has apparently had to go back that far in order to find an expression of employee opposition which I think is a rather weak approach to a very serious matter.

Now, the hotel association, and as far as I know, I confine myself to the hotel association and by that I mean the American Hotel Association has conducted a vigorous campaign directed to the employees involved, a campaign which in effect says, "You don't want this coverage. Tell your representative that you don't want it."

And we offer here as part of the record an example of the literature. It is veiled and confusing. In essence it leaves the employee with this thought: "If tips coverage is legislated, you will have to pay income taxes to the Government which you may be getting away with now."

I heard the representative of the employer say something to the effect a few minutes ago that whenever we discussed this with the employees or whenever we explain to them what it is they are against the tips coverage. If this is the kind of explanation it is not difficult to see why there is employee mail which may be in opposition.

I will read you an example of it.

Tax on tips poses some real problems for employees—

They don't say it imposes taxes on employers as they have been telling you.

Very few know all its burdens. There are very severe penalties for violations. We don't think many employees would want it if they knew all about it:

Then they go on to explain the reporting method, and the reference you see here is to section 205 of the old bill but still it is intact in this

bill the reference is the same. What they say is that "You certainly have an interest in this matter. You may want to oppose the section. You might want to write to your Congressmen. We suggest that you contact your Congressmen now."

To me it is quite clear that the employers don't want it, and that their time, many of those profits they may have been having must have been spent in persuading the employee that he doesn't want it.

Employer oppossition is actually based regardless of the excuse on the fact that this coverage is going to cost them more money in social security taxes, and they would like to keep that amount down as low as possible, and this was borne out by the figures that were presented to you by the Restaurant Association.

Accordingly, we hear such statements as, "We are quite in sympathy but we think that this is a self-employment matter."

Tip workers are not self-employed. They are employees, and, therefore, must be treated as such in all areas, including social security.

Imagine the implications behind the self-employment, Senator Ribicoff. I see three, no unemployment insurance which all tip workers have. No workmen's compensation which all tip workers have. No union organizations which a large number of tip workers have. These are only some of the implications of the idea of self-employment for tipped workers.

Now, a self-employed man sets up a little business somewhere. He doesn't go into a place where he has to sign a contract, where he has to obey the rules of the establishment. Where he has to wear their uniform, where they must agree to certain safety rules for them, where they have to pay unemployment insurance taxes, and have the right to hire and fire. So, that this is—I don't quite know how to describe it, it is a drowning man clutching at a straw to think of this in terms of self-employment.

Now, not all hotel employers have the backward views on this problem that the opposition would indicate our own experience in New York City is an example of far-sighted thinking on the part of the New York City Hotel Association, which does feel a responsibility in this area.

Upon the presentation by our union in collective bargaining negotiations of the problem of social security coverage in this tipped area, both sides reached an agreement recognizing that tips are part of wages, and that tipped workers covered by our collective bargaining agreement are deemed to earn at least $70 a week in cash wages and tips, and since this section of our contract was quoted a few minutes ago by the representative of the restaurant association it must have occurred to you, Senator, why were banquet waiters excluded? The banquet waiters were excluded because they are covered. They are covered under the regulations of the Social Security Administration. So we haven't had any problem of asking for tips coverage of banquet waiters. Accordingly the employers involved deducted the employee's share for social security and for withholding, and contributed their own share for social security.

Our agreement has been recognized by the Social Security Administration, and the Internal Revenue Department, as of June 1, 1963, the effective date of the agreement.

Tipped workers covered by our collective bargaining agreement have a certain amount of tip coverage under social security. We are offering a copy of the approval for your record.

I think that the restaurant association offered this absolutely leading type of agreement as a substitute for legislation. This happens to be one of the most unique things that has ever happened but it is not a substitute for legislation. It isn't the first time that a labor union has led the way toward a revision of social problems which will then be followed by legislation, which will cover the entire country and give to the unorganized the benefit of what the union has been able to do by collective bargaining.

There are people all over the country here who are not organized, unfortunately, and who do need this help, not only here, but in the minimum wage area as well.

Now, the correction of a long-standing inequity is at hand in section 313 of this bill.

Well, since the restaurant association went as far back as 1957, we will take the privilege of going back to 1948, and say that the coverage of tips for social security——

Senator RIBICOFF. I assume most of these things you are talking about are not in your prepared statement?

Miss ALGASE. Yes.

Senator RIBICOFF. Fine, you seem to be wandering around.

Miss ALGASE. No, I interpolate every now and then, Senator.

Senator RIBICOFF. Just that time is running out.

Miss ALGASE. I am reading now the rest of what is in——

Senator RIBICOFF. I mean you can interpolate, it is perfectly all right. I thought you would make your written statement part of the record as read and you can interpolate accordingly.

Miss ALGASE. I would be perfectly happy in the interest of time to skip the balance of page 3 of my statement which refers to Senator Lehman's interest in this behalf and some of his quotes particularly in relation to the question of employment of tipped workers, because he said, "These people are required to include moneys received in this way in their income tax returns. I can think of no reason why they should not be entitled to have these moneys accounted for social security."

Now, 9 years later the situation is still uncorrected. The tipped worker presently maintaining a reasonably good standard of living on the basis of wages and tips is reduced at the time of old age to the lowest rung of the social security ladder, and we offer for your record an analysis of the difference in these benefits which is based on our own experience.

I have a copy of that for the record.

Senator RIBICOFF. That will be placed in the record with your prepared statement at the end of your testimony.

Miss ALGASE. Yes.

From this it appears that social security benefits without tips inclusion would be $73 a month whereas if it were based on only $70 a week the benefits would be $116. But this is for our section of the community which has the benefit of a contract, as I have pointed out.

The correction of the abuses in your hands and we, 35,000 of us, and more believe that you will correct it by approving section 313. May

we add that Local 471 of the Hotel & Restaurants Employees International Union covering the Albany, Schenectady, and Troy area have asked us to include their support with ours.

Senator, I have an additional section which is not related to tips but to the hospital portion of the bill. With respect to the hospital portion of the bill we support amendment No. 79 which would include vital hospital services customarily rendered as such but which are presently excluded as the bill stands.

We have a pension, insurance, and medical care program set up by our collective bargaining agreement, and I will submit a copy of the various services.

(The material referred to follows:)

HEALTH SERVICES FOR EMPLOYEES OF THE HOTEL INDUSTRY COVERED BY THE INDUSTRYWIDE COLLECTIVE BARGAINING AGREEMENT

PENSIONERS

(A) At the Health Center (50th Street and 10th Avenue) pensioners will be given:

(1) Ambulatory care; (2) hospital care by health center physicians provided pensioner carries hospital insurance (usually Blue Cross).

(B) At FMO's (family medical offices) if living in covered zones:

(1) Ambulatory care; (2) hospital care by FMO physicians provided pensioner carries hospital insurance; (3) home care.

(C) Pensioners living in FMO covered zones should be treated at the respective FMO. They may, however, elect to be treated at the health center. They cannot shuttle from one to the other or be treated at both.

(D) These services are not extended to spouses or dependents of pensioners.

SUFFOLK AND NASSAU COUNTY RESIDENTS

A HIP program covers eligible members and families living in these areas.

WESTCHESTER, NEW JERSEY, STATEN ISLAND RESIDENTS

On April 1, 1964 a "fee-for-service" plan became effective for eligible members and families. This plan provides partial reimbursement for office, home, and hospital care by MD's of the patient's own choice, according to a schedule of fees set by the Union Family Medical Fund.

QUEENS RESIDENTS

All eligible members and family dependents living in Queens are serviced by the Queens Family Medical Office at 91-31 Queens Boulevard, Telephone TW-9-8855.

BROOKLYN RESIDENTS

An agreement has been signed with the Brooklyn Hospital, at Ashland Place and DeKalb Avenue. A family medical office similar to the other FMO's now in operation will be opened early in 1966. Meantime, the member himself or herself will continue to get medical care at the health center, (50th Street and 10th Avenue) and a temporary surgical and obstetrical program is provided for spouses and family dependents.

BRONX RESIDENTS

All eligible members and family dependents living in the Bronx are serviced by the Family Medical Office at 360 East 193d Street, telephone WE-3-2300.

MANHATTAN RESIDENTS

(a) All eligible members and family dependents living in postal zones 21, 22, 26, 27, 28, 29, 35, and 37 are serviced by the Family Medical Office at 21 East 105th Street, telephone EN-9-2211.

(b) All eligible members and family dependents living in postal zones 1 through 7, 9 through 14, 16 through 19, 36, and 38 (the area on the East and West Sides

below Central Park) are serviced by the Family Medical Office at 84 Fifth Avenue, telephone YU-9-6300.

(c) For families living in postal zones 23, 24, and 25 (the West Side area from 59th Street up to about 116th Street) service for spouses and dependent children only, but not the member, is provided at the South Manhattan Family Medical Office at 84 Fifth Avenue, telephone YU-9-6300. The member himself or herself is still to use the health center at 50th Street and 10th Avenue, telephone JU-6-1550.

TEMPORARY SURGICAL AND OBSTETRICAL PROGRAM

This program, which provides reimbursement for surgical and obstetrical benefits only, is still in operation. It is applicable to dependents of eligible members who are not included in any of the plans described above. Reimbursement is made according to a set schedule of fees.

HEALTH CENTER

Members, but not family dependents, who are not included in any of the above described programs, will continue to be covered by the health center at 50th Street and 10th Avenue, telephone JU-6-1150.

IF THE EMPLOYEE GETS SICK ON THE JOB

Emergency medical care for those who become ill on the job is being centralized at the health center, 50th Street and 10th Avenue.

Regardless of where the employee lives, he should proceed as follows if taken ill at work and in need of a doctor:

At night and on weekends and holidays when the health center is closed, call its number JU-6-1150, and a doctor will be sent.

During the day when the health center is open go directly to its emergency clinic if able to travel. If too sick to travel, call JU-6-1150.

Miss ALGASE. We provide ambulatory medical care for the elderly pensioned workers in our industry, who are also receiving social security benefits and who would be covered by the proposed bill.

We provide medical care and hospital care for these aged if they can keep up their Blue Cross payments. Part of this hospitalization has traditionally included diagnostic, X-ray and laboratory tests, electrocardiograms, basal metabolism readings, and other customary hospital services.

The proposed exclusion is a dilution of the concept of hospital care and I will not read the rest of my statement on this.

We need not go into the broad impact which the exclusions would have on hospital practice in general and on hospital-physician relationships. The inherent dangers are evident in the critical statements of Senators—and Senator Ribicoff in your own answer to questions that we raised on this point.

But we do wish to state that we have a direct and specific interest in the integrity of a hospital system which includes the specialist services.

Our union, as I have stated, provides free and comprehensive medical care both to the worker and the workers' family through a chain of medical offices which are attached to and are virtually an integral part of major New York City hospitals.

In short, a blow at hospitals, and that is what the exclusions are, is a blow at our program and the people it serves. We ask for approval of amendment 79 and I ask and apologize for going over my time.

Senator RIBICOFF. Thank you very much, Miss Algase.

(The full prepared statement and attachments follow:)

STATEMENT OF JULIA ALGASE, NEW YORK HOTEL AND MOTEL TRADES COUNCIL, IN SUPPORT OF SECTION 3 OF H.R. 6675 AND IN SUPPORT OF AMENDMENT 79 TO INCLUDE VITAL HOSPITAL SERVICES PRESENTLY EXCLUDED

My name is Julia Algase. I am legislative counsel and assistant to Jay Rubin, the president of the New York Hotel & Motel Trades Council which represents 35,000 hotel and motel workers in New York City under collective bargaining agreement with the Hotel Association of the City of New York.

Present with me today is Vangel Kamaras, a vice president of local 6, one of our constituent unions, and chairman of the Social Security and Tip Committee of the Hotel Trades Council, as well as other representatives of the large number of tip workers that we represent among the 35,000. The tip employees we represent are waiters, waitresses, bellmen, baggagemen, and doormen.

We come here to ask you to retain intact section 313 of H.R. 6675, the section which defines tips as wages and provides a reporting method for that purpose.

This proposal has been opposed by the American Hotel Association. We are told, as excuse for opposition, either that the program will be difficult to administer or that the employees involved do not want the coverage. Employers have conducted a vigorous campaign directed to the employees involved—a campaign which in effect says—"You don't want this coverage. Tell your representative that you don't want it." We offer an example of the literature for your record. It is veiled and confusing. In essence it leaves the employee with this thought: "If tips coverage is legislated, you will have to pay income taxes to the Government which you may be getting away with now."

Employer opposition is actually based, regardless of the excuse, on the fact that this coverage is going to cost them more money in social security taxes, and they would like to keep that amount down as low as possible. Accordingly, we hear such statements as, "We are quite in sympathy but we think that this is a self-employment matter." Tip workers are not self-employed. They are employees and therefore must be treated as such in all areas, including social security. Since tip earnings are related directly to employment and flow out of that employment and an income tax is due on those tips, tip earnings must be included for social security purposes.

Not all hotel employers have the backward view on this problem that the opposition would indicate. Our own experience in New York City is an example of farsighted thinking on the part of a hotel association—the New York City Hotel Association—which does feel a responsibility in this area. Upon the presentation by our union, in collective bargaining negotiations of the problem of social security coverage in this tip area, both sides reached an agreement, recognizing that tips are part of wages and that tip workers covered by our collective bargaining agreement are deemed to earn at least $70 a week in cash wages and tips. Accordingly, the employers involved deducted the employee's share for social security and contributed their own share. Our agreement has been recognized by the Social Security Administration and the Internal Revenue Department as of June 1, 1963, the effecttive date of the agreement. Tip workers covered by our collective bargaining agreement have a certain amount of tip coverage under social security. We are offering a copy of the approval for your record.

The correction of a long-standing inequity is at hand in section 8 in this bill. As far back as 1948 the coverage of tips for social security purposes was recommended in the report of the Advisory Council on Social Security. In 1956, 8 years later, Senator Herbert Lehman offered an amendment to the Social Security Amendments of 1956 on the Senate floor. These were his words:

"There are thousands of people in the United States who receive part of their wages in the form of tips—taxicab drivers, waiters and waitresses, barbers, bellhops, and others. These people are entitled to the same degree of social security coverage as the rest of our citizens. They should not be penalized simply because part of their earnings are not paid to them directly by their employers. These people are required to include moneys received in this way in their income tax returns. I can think of no reason why they should not be entitled to have these moneys accounted for social security."

Now, 9 years later, the situation is still uncorrected and a tip worker presently maintaining a reasonably good standing of living on the basis of wages and tips is reduced at the time of old age to the lowest rung of the social security ladder. We offer for your record an analysis of the difference in these benefits which is based on our own experience. From this it appears that social security benefits

without tips inclusion would be $73 a month, whereas if it were based on $70 a week, the benefits would be $116. But this is for our section of the community which has the benefit of contract and higher base wages than most parts of the country. The unorganized, particularly those who do not have the protection of the Federal minimum wage, are receiving exceedingly low hourly rates—the only amount reflected in their social security benefits.

The correction of the abuse is in your hands and we—35,000 of us—believe that you will correct it by approving section 3.

May we add that local 471 of the Hotel & Restaurant Employees International Union covering the Albany, Schenectady, and Troy area have asked us to include their support with ours.

Now, with respect to the hospital portion of the bill, we support amendment No. 70 which would include vital hospital services customarily rendered as such but which are presently excluded as the bill stands.

We have a pension, insurance, and medical care program set up by our collective bargaining agreement. We provide ambulatory medical care for the elderly pensioned workers in our industry who are also receiving social security benefits and who would be covered by the proposed bill. We provide medical care in hospital for these aged if they can keep up their Blue Cross (hospital insurance) payments. Part of this hospitalization has traditionally included diagnostic, X-ray and laboratory tests, electrocardiograms, basal metabolism readings, and other customary regular hospital services—such as those of radiologists, pathologists, and anesthesiologists.

The proposed exclusion is a dilution of the concept of hospital care. It is a concession to the efforts of the American Medical Association to obstruct enactment of a social security program which would meet adequately the high costs of hospital care for the elderly. Putting these customary hospital services in the voluntary supplementary medical portion of the legislation means billing the patient, a thing alien to the concept of insurance for hospital care.

We need not here go into the broad impact which the exclusions would have on hospital practice in general and on hospital-physician relationships. The inherent dangers have been made evident in the critical statements of Senators Douglas, Neuberger, Gruening, and others. But we do wish to state that we have a direct and specific interest in the integrity of a hospital system that includes the specialist services. Our union provides free and comprehensive medical care, both to the worker and the worker's family, through a chain of medical offices which are attached to, and are virtually an integral part of, major New York City hospitals. In short, a blow at hospitals—and that is what the exclusions are—is a blow at our program and the people it serves.

We ask your approval of amendment No. 79.

U.S. TREASURY DEPARTMENT,
INTERNAL REVENUE SERVICE,
DISTRICT DIRECTOR,
New York, N.Y., August 25, 1964.

MR. JAY RUBIN,
President, New York Hotel Trades Council,
New York, N.Y.

DEAR MR. RUBIN: At the request of the Director, Tax Rulings Division, I am notifying you of the status for social security, Federal unemployment tax, and withholding of income tax of a stated figure of $70 weekly in cash and tips referred to in paragraph 31 of the collective bargaining agreement of September 28, 1962, between the New York Hotel Trades Council, AFL-CIO, and the Hotel Association of New York City, Inc.

On the basis of advice received by me from the Tax Rulings Division, it is now held that such tips constitute "wages" to the extent that the amount thereof, when added to wages otherwise received by the employee from the employer, equals $70 for services performed during a complete weekly payroll period (or equals a pro rata portion of $70 for services performed during a part of a weekly period). This determination is applicable for purposes of the taxes imposed under the Federal Insurance Contributions Act and the Federal Unemployment Tax Act and for the purposes of the collection of income tax at source on wages.

The effective date of this determination shall be in accordance with the following rules:

1. For purposes of the taxes imposed under the Federal Insurance Contributions Act this ruling will be applicable to tips received in pay periods beginning on or after June 1, 1963, the effective date of section 31 of the collective bargaining agreement.

2. The tax imposed under the Federal Unemployment Tax Act will apply under this ruling only to tips received on or after January 1, 1964.

3. For purposes of income tax withholding this determination will apply (1) to the period beginning June 1, 1963, and ending at the close of the pay period which includes the date of this letter, but only to the extent that income tax has been withheld by the employer and has not been returned to the employee, and (2) to all pay periods beginning after the date of this letter.

Inasmuch as the collective-bargaining agreement has been in effect since June 1, 1963, and, pursuant to section 31 thereof, payments have been made by tip employees and their respective employers to an impartial chairman, as escrow holder, based upon the consideration as wages of certified and accounted gratuities in amounts which, when added to their respective weekly salaries, shall equal the sum of $70, it will become necessary for the respective employers to report and pay over to the Internal Revenue Service the full amount of the employment taxes and withheld income tax due in accordance with the effective dates stated above.

Instructions for the procedure to be followed in reporting these taxes will be communicated to the employers through their trade association.

Please notify your membership of this determination and that the ruling as to the status for employment tax purposes of the $70 referred to herein does not affect the amount to be included in gross income by the members for Federal income tax purposes, as all tips and gratuities received by such members are includible in gross income without limitation.

Very truly yours,

CHARLES A. CHURCH, *District Director.*

Social security benefits

Year	Weekly contract cash wage	Annual cash wage (52 weeks)	Year	Weekly contract cash wage	Annual cash wage (52 weeks)
1951	$21.80	$1,133.60	1959	32.40	1,684.80
1952	21.80	1,133.60	1960	33.65	1,749.80
1953	23.00	1,196.00	1961	34.90	1,814.80
1954	24.20	1,238.40	1962	36.15	1,879.80
1955	25.40	1,320.80	1963	37.15	1,931.80
1956	27.40	1,424.80	1964	38.15	1,983.80
1957	29.40	1,528.80			
1958	30.90	1,606.80	Total		21,627.60

Average annual wage after 1950	$1,544.83
=social security benefits	73.00
Average annual wage based on	70.00
=social security benefits	116.00

Senator RIBICOFF. The committee will stand adjourned until tomorrow morning at 10 o'clock.

Miss ALGASE. Senator Ribicoff, I have been asked if these two gentlemen could make a brief statement.

Senator RIBICOFF. All right.

You are taking more time than any other.

Mr. ZUCCA. E. Sarni Zucca. I have a statement here, Senator, but I am not going to read it. I merely wish to make two brief additions to a statement already made by Miss Algase and it is this: that upon retirement these workers qualify for social security benefits substantially inferior to those of other workers who pay the same taxes. The difference in the rate of benefits may mean the difference between economic survival and destitution in old age. However, the same applies

to the survivors, the widows and the orphans when the head of the family dies.

In other words, what is involved here is not only the worker himself, but also the family.

No. 2. A considerable number of employers have expressed support for this bill out of a sense of fairness toward their employees.

Third, as to cost mentioned by the employers, the additional social security taxes involved will be no higher and no lower than every other employer now pays.

As a matter of fact, employers of tipped employees have enjoyed an advantage over other employers for many years.

Thank you.

Senator RIBICOFF. Thank you very much.

I understood you were informed that every group would have one witness, and if you have any statement you can place them in the record at this point, which is the rules the committee has been operating under all these hearings.

You are the only one who has had an exception to it.

Miss ALGASE. I am very sorry. I was just asked by Mr. Zucca if I could make that application for him. I had not intended to violate any promise.

Senator RIBICOFF. What do you have, sir?

All right.

Senator Douglas, who had to leave the meeting, has asked that his statement in support of his amendment 178 to provide for the administration by the Railroad Retirement Board of the hospital insurance program as it relates to railroad employees be placed in the record.

(The statement follows:)

STATEMENT OF SENATOR DOUGLAS

The bill H.R. 6675, as passed by the House, omitted the provisions contained in the original bill (H.R. 1) with respect to the jurisdiction of the Railroad Retirement Board over the administration of the hospital insurance program as it relates to railroad employees. My amendments would restore to the Board such jurisdiction.

The provisions which my amendments would restore are not new. Pursuant to an agreement of long standing between the Secretary of Health, Education, and Welfare and the Railroad Retirement Board, such provisions were incorporated in the 1961 bills for hospital insurance benefits (H.R. 4222, introduced February 13, 1961, and S. 909, introduced the same date). They were incorporated again in 1963 (H.R. 3920, introduced Feburary 21, 1963, and S. 880, introduced the same date), again in 1964 (H.R. 11865, passed by the Senate on September 8, 1964) and again in 1965 (H.R. 1, introduced January 4, 1965, and S. 1, introduced January 6, 1965). This agreement between the 2 agencies was, and is, in conformity with the long established congressional policy of conferring upon the Railroad Retirement Board jurisdiction with respect to benefits for railroad employees, their dependents and survivors. As is well known, the Railroad Retirement Board administers the railroad retirement program which provides retirement benefits for railroad employees, their dependents and survivors. The Board also administers the railroad unemployment and sickness insurance program which provides protection against unemployment and sickness of railroad employees. It was and is, of course, logical that the Board administer the hospital insurance program as it relates to railroad employees, their dependents and survivors, particularly in view of the fact that their eligibility for payment for hospital services is derived from the rights of railroad employees to benefits under the railroad retirement program.

There is now considerable cooperation between the railroad retirement and social security systems through mutually agreed upon procedures to implement the existing statutory provisions for coordination of the 2 systems. Accordingly, for the purpose of smooth and efficient administration of the hospital insurance program, procedures have been carefully worked out between the 2 agencies to make certain that the administration by the Railroad Retirement Board of the hospital insurance program as it relates to railroad employees would not result in any administrative problems to either of the agencies or to hospitals.

The Chairman of the Railroad Retirement Board has been authorized by the Commissioner of Social Security to advise me that the Department of Health, Education, and Welfare has no objection to the adoption of my amendments to the bill H.R. 6675.

Senator RIBICOFF. The committee will stand adjourned until tomorrow morning at 10 a.m.

(Whereupon, at 11:15 a.m., the committee adjourned, to reconvene at 10 a.m., Wednesday, May 19, 1965.)

SOCIAL SECURITY

WEDNESDAY, MAY 19, 1965

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

The committee met, pursuant to recess, at 10:10 a.m., in room 2221, New Senate Office Building, Senator Eugene J. McCarthy presiding.

Present: Senators McCarthy, Douglas, and Gore.

Also present: Elizabeth B. Springer, chief clerk.

Senator MCCARTHY. The committee will come to order.

The first witness is Dr. Vincent W. Archer, Charlottesville, Va.

Dr. Archer, Senator Byrd said he is sorry he couldn't be here this morning to hear your testimony, but I am sitting in for him.

STATEMENT OF DR. VINCENT W. ARCHER, CHARLOTTESVILLE, VA.

Dr. ARCHER. Thank you.

Mr. Chairman, thank you for allowing me to present my views on certain areas of H.R. 6675; namely, the noninclusion of radiology as a "hospital service."

I come, not as a representative of the American Medical Association, I have been a member of the house of delegates for 14 years, not representing the American College of Radiology of which I have been president, not representing the Medical Society of Virginia, of which I have been president.

My presentation is that of an individual intensely interested in the future supply of radiologists, so interested that I am paying my own expenses out of my markedly diminished income as a semiretired professor in a medical school.

Just a word regarding my right to have a considered opinion. Until 1961, when I was retired on account of age, I had been chairman of the Department of Radiology at the University of Virginia Medical School for over 37 years and had been responsible for recruitment and training of 73 residents in radiology.

Radiology is a highly developed medical specialty requiring a medical degree, 1 year of internship and 4 years of radiological training before becoming qualified as a specialist. In its rapidly expanding scope, radiology, comprises not only the relatively simple diagnostic procedures, but also very complicated maneuvers such as passing a catheter, a small tube, into the heart, into the aorta, into the kidneys, and visualizing the vessels of the brain.

The use of radioactive materials in mapping various organs and the treatment of malignancy by cobalt and isotopes are also covered in this training program. This, then, is truly the practice of medicine,

not a function of a nonmedical organization such as a hospital. All of the residents in our department are trained in, and personally perform, all of the procedures enumerated and many others too numerous to mention. In addition, radiologists treat about 70 percent of all patients with cancer. So much, then, for the establishment of radiology as a medical service, not as a hospital service.

My grave concern is over the increasing difficulty in recruiting sufficient numbers of high-class medical graduates to supply this ever-increasing deficit of qualified radiologists. May I quote from the testimony presented by the American College of Radiology to the House Ways and Means Committee in February of this year.

> The use of X-rays in the diagnosis and treatment of disease has increased more than 12 percent annually. At the same time, the increasing complexity of new procedures, such as intricate heart examinations and the other examinations which I have described, makes the actual annual increase in X-ray work about 20 percent.
>
> In 1963 only three out of four openings in X-ray training programs for physicians were filled.

This compares with, if I may quote some more statistics, compares with internal medicine, 81 percent, ophthalmology, 94 percent, orthopedic surgery, 81 percent, surgery, general surgery, 81 percent, and we were able to recruit only 76 percent.

> Thus, only about 500 new radiologists were added to the approximately 7,000 specialists already practicing. With normal attrition of deaths, the profession increases its number by about 300 yearly, less than 5 percent. Thus, the supply is not keeping pace with the need.

Still quoting from the report:

> If the specialty becomes less desirable to young physicians because of its segregation as a hospital service, its ability to recruit needed young physicians will be seriously impaired. This problem will be compounded if proposals in the President's Health Message urging the establishment of regional centers for diagnosis and treatment of cancer, strokes and heart disease are implemented.

This has been our experience in my institution. It is difficult to get medical students and young physicians interested in the field of radiology when they feel that it will be dominated by the hospitals and lay boards of trustees.

Under such circumstances, financial considerations on the part of lay boards, may overshadow medical care in the minds of these boards. In addition, there is a very definite loss of professional dignity when a specialty is set apart in this way from other physicians. This is really the voice of experience speaking. As applied locally, my comments date to the distant past, up to 1937, to be exact, not to the present, but this can and does happen elsewhere and the younger men know it.

The same reasoning undoubtedly applies to the specialties of pathology, anesthesiology and psychiatry, but I speak only of radiology of which I have had such an intimate knowledge over so long a time.

In closing, may I interpolate that on the basis of my past experiences over a long period of time with all forms of medical practice on a local, State, and National level, I am opposed to the medical sections of H.R. 6675 as a whole, and the basis of this long experience dates back to my war, World War I, in which I was a first sergeant, then adjutant of a general hospital, and since then I have been working in an institution, the University of Virginia Hospital, which is a governmental institution, and medicine is not practiced quite as well as we

would like to see it practiced due to many interferences by governmental agencies.

However, if this bill should pass, please consider the irreparable damage to the branch of the medical profession of which I am a member and do not include the medical services of the radiologist within the hospital benefits section of this bill.

Thank you, sir.

Senator McCARTHY. Dr. Archer, is there any reason as to why radiologists should be excluded as distinguished from the other three or four specialties that are included?

Dr. ARCHER. No, sir; they all belong in the same basket, but I can speak personally only from the standpoint of radiology, because I am so thoroughly conversant with what is going on in radiology.

Senator McCARTHY. Isn't it a practice in many hospitals to have the radiologist on some kind of an annual salary rather than to have him practicing independently?

Dr. ARCHER. That is true, that in a great many hospitals that is true. In our own State, however, we have reviewed the contracts of all of the folks in the hospitals and except in the State teaching hospitals they are not on salary but are either on a percentage or bill the patients independently, separate from the hospital bill.

Senator McCARTHY. You mean they receive a percentage of what the hospital charges for its services?

Dr. ARCHER. On what the radiologists charge. The radiologists in Virginia, the whole State of Virginia set the charges and then the hospital gets a certain percentage of the collections.

Senator McCARTHY. I see.

Is it possible that you could distinguish between the diagnostic services and the treatment aspect of it?

Dr. ARCHER. Yes, sir, it is.

Senator McCARTHY. Would it be possible to include the one as a part of the hospital charges and have the other treated as having a private practice?

Dr. ARCHER. It certainly would, the same as thoracic surgery is differentiated from neurosurgery, but this argument that applies to one applies to the others, as far as the thing I am interested in, and that is the recruitment of future radiologists.

Senator McCARTHY. I have no more questions.

Thank you very much.

Dr. ARCHER. Thank you, sir.

Senator McCARTHY. William A. Callahan of the International Association of Industrial Accident Boards and Commissions.

STATEMENT OF WILLIAM A. CALLAHAN, PRESIDENT, THE INTERNATIONAL ASSOCIATION OF INDUSTRIAL ACCIDENT BOARDS AND COMMISSIONS; ACCOMPANIED BY JOSEPH E. McGUIRE, COMMISSIONER, INDUSTRIAL ACCIDENT BOARD, BOSTON, MASS.; JOHN V. KEANEY, COMMISSIONER, MAINE INDUSTRIAL ACCIDENT COMMISSION, PORTLAND, MAINE; AND DANIEL T. DOHERTY, CHAIRMAN, WORKMEN'S COMPENSATION COMMISSION, BALTIMORE, MD.

Mr. CALLAHAN. Mr. Chairman, my name is William A. Callahan. I am a Workmen's Compensation Commissioner from the State of

Oregon and am president of the International Association of Industrial Accident Boards and Commissions.

I have with me Mr. John Keaney on my immediate left, who is a commissioner from the State of Maine, and is the vice president of our international association.

On my right hand I have Mr. Dan Doherty, chairman of the Maryland Workmen's Compensation Commission, the immediate past president of our international association, and on my far left, I have Mr. Joseph McGuire, who is a commissioner from the State of Massachusetts, and is the chairman of our legislative committee.

Senator McCarthy. How do you have so many Irishmen in control of this organiztaion?

Mr. Callahan. May I also say, Mr. Chairman, that the chairman could also be an Irishman.

Senator McCarthy. It could be.

Mr. Callahan. So perhaps we are among friends.

Senator McCarthy. Go ahead.

Mr. Callahan. As president of the International Association of Industrial Accident Boards and Commissions, I am authorized to make this request by vote of the membership at the last convention.

Membership of our association consists of the workmen's compensation boards and commissions of 48 of the States of our Nation, plus the provinces of Canada and other nations. The members of these boards and commissions are actively engaged in the administration of workmen's compensation and constitute the best informed group on matters of workmen's compensation.

This association has not opposed social security, nor has it opposed the medicare program. It does not oppose disability payments through social security for those persons disabled from nonoccupational injuries, nor is it opposed to social security benefits after retirement age to those disabled by occupational injuries.

By membership vote, this association has opposed the encroachment of social security into the field of workmen's compensation. As administrators we have direct knowledge of the harm being done. It is clear to us that this is detrimental to our Nation. As citizens we feel compelled to respectfully ask you to delete that part of section 303 redefining disability from H.R. 6675 and consider it separately on its merits, or to amend that section to eliminate the application of its provisions to workmen's compensation claimants.

That portion of section 303 is not relevant to the medicare program, and if deleted the medicare program would not be affected. This was attached to the popular medicare bill very late, and those adversely affected did not have an opportunity to be heard.

There is already an overlap in payments to permanently and totally disabled workmen's compensation claimants, and disability benefits of social security. Parts of section 303 would compound this problem by extending the overlap into payments for temporary disability by recognizing any disability of more than 6 months' duration.

Several months ago the IAIABC agreed to cooperate with the Social Security Administration in a joint study of overlapping benefits. Recently the House Ways and Means Committee directed the Social Security Administration to conduct a study of overlapping benefits. A few weeks ago our association received a communication

from Commissioner Robert Ball asking for the association's participation in this broader study. Our association has agreed to do this.

We respectfully direct your attention to the inconsistency of ordering a study and before such a study is made, taking action on the matter under study. Our association, being aware of the adverse effects, stands ready to cooperate in the study. We ask that you at least delay action until the study is made.

Rehabilitation of occupationally injured workmen is an integral part of workmen's compensation and is second in importance only to prevention of injuries. When overlapping payments exceed wages, efforts to rehabilitate are nullified. It is astonishing that while the Labor Department of the Federal Government works diligently to rehabilitate injured workmen, the Social Security Administration, through encroachment into workmen's compensation, makes rehabilitation extremely difficult.

Workmen's compensation is based upon the doctrine of occupational injuries being a cost of production and as such is to be paid for by the employing entity. This was the theme of the speeches and writings of the advocates of this doctrine during the time when State workmen's compensation laws were being enacted. The pronouncement of less prominent persons have been lost, but those of Theodore Roosevelt have been preserved and are available in the Theodore Roosevelt Cyclopedia, which must be available in the Library of Congress. He maintained that it was as much the obligation of an employer to pay for costs of occupational injuries as to pay for repairs to broken machinery. Workmen's compensation laws implement this doctrine.

Some years later the U.S. Supreme Court in *Cudahy Packing Co. of Nebraska* v. *Parramore*, 263 U.S. 418, affirmed the same precept. The United States Chamber of Commerce in its yearly publication "Analysis of Workmen's Compensation Laws", on page 3 of the 1964 edition, continues to state that occupational injuries are a cost of production. No one disputes this doctrine.

Workmen's compensation is financed by insurance plans that provide variable premium rates, recognizing the comparative hazard of the employer's operations. These rates are further modified for each employer in keeping with his claim costs, which reflect the efficiency of his safety program.

Thus the principle of insurance is carried out, the risk is spread, and each employer is rewarded for safety efforts or penalized for lack of safety.

Incentives are provided to install safety programs, even at a substantial cost, because of the saving in workmen's compensation premiums. History proves that workmen's compensation, through the incentives provided, has been the greatest single force in the reduction of occupational injuries.

It is claimed that State workmen's compensation laws do not fully implement the doctrine of occupational injuries being a cost of production.

In many cases this is true and the corrections must be made by upgrading the workmen's compensation laws where needed. As workmen's compensation administrators and through our association, we advocate this. Our efforts are bearing fruit, as attested by the upgrading of benefits in State laws this year. These efforts should be

encouraged, not hampered or nullified by the encroachment of social security into the field of workmen's compensation.

Social security funds are not the proper source from which to make payments for occupational injuries. One-half of the payments to social security is deducted from workers' pay checks. Thus when social security funds are used to pay for occupational injuries, the workers are required to pay one-half of the employers' legitimate obligation. This violates the basic doctrine of workmen's compensation.

The other half paid by employers at a fixed rate regardless of the hazard of the employment, and with no recognition of safety effort, is unjust as a system of financing the cost of occupational injuries and also violates the basic doctrine of workmen's compensation.

Shifting of payment for occupational injuries from workmen's compensation to social security is fundamentally wrong and can only be rationalized by the end justifying the means. If workmen's compensation is deficient it should be upgraded, not supplemented from the wrong source. Two wrongs never did make a right.

It is undeniable that social security funds are not the proper source of payment for occupational injuries. There being no incentive for the employer to promote safety, the deterioration of safety programs will result in increased human suffering as well as economic loss.

It may be claimed that it is difficult to separate occupational injuries from those of nonoccupational origin. Administrative difficulty in this case is greatly exaggerated, and even if the difficulty existed is not justification for charging the cost to the wrong source of funds.

May I digress a moment, Mr. Chairman, in workmen's compensation we have to do that every day and while it is a job it is not a costly one. We have to do it right along.

The International Association of Industrial Accident Boards and Commissions will ever strive to improve and upgrade workmen's compensation laws so that the doctrine of occupational injuries being a cost of production is fully implemented. The association requests help from all who would see this noble purpose accomplished.

To that end the association respectfully requests your honorable body to delete that portion of section 303 redefining disability from H.R. 6675. It should not be considered until the study ordered by the House of Representatives has been completed. At the very least, the association requests that section 303 be amended so that its provisions do not apply to workmen's compensation claimants.

Mr. Chairman, I respectfully submit this on behalf of our association.

Senator McCarthy. Thank you very much, Mr. Callahan.

Do either of the other men wish to testify or are they just here to support your position?

Mr. Callahan. No, but they might be here to give me a little moral support and also answer some questions if they should be directed.

Senator McCarthy. In the case of Oregon, what is the practice with reference to the time in which you begin paying disability payments?

Mr. Callahan. You mean the first payment?

Senator McCarthy. How long must a man be disabled before he is eligible? Does it vary——

Mr. CALLAHAN. The record as of very late is 7 and a fraction days, and we have no limit on the time as far as time loss. There is no limit either in dollars or in time.

Senator MCCARTHY. How long does the average disability last? That is, compensable disability?

Mr. CALLAHAN. The average disability, of course, is not very great. Of course, most of the injuries wouldn't even have a disability at all, most of them are very minor. I couldn't tell you exactly how long but the ones we are talking about, of course, are the important ones, and we will have some that drag on for several months, sometimes even a couple of years.

Senator MCCARTHY. Not many would go beyond 6 months?

Mr. CALLAHAN. Not too many.

Senator MCCARTHY. So your really won't have much overlap since this payment doesn't begin until 6 months have elapsed and most of the people under the State plans will be pretty well taken care of.

Mr. CALLAHAN. I would like to put that just a little bit differently. I don't believe it is exactly the numbers who are involved. I would prefer to put it, and as we feel, and I certainly feel that way myself, it is more the principle that is involved rather than the numbers.

Now, I don't think the numbers are so great, but it is the principle that is involved, and as you probably know from experience, when you have trouble spots you don't have to have very many of them to cause much trouble.

Senator MCCARTHY. Well, I don't really think I need press it any more. I understand your position. This I think is the key, the question of the overlapping: whether you want to serve the more general good or be concerned about the one or two who might receive special benefits. It has been proposed that we impose an income tax on disability payments once the total disability payment is in excess of what the man's income was before he was disabled. Do you think that might be helpful in keeping alive their incentive to go back to work?

Mr. CALLAHAN. Well, I hate to see us get away from the basic principle on which workmen's compensation has been developed, that it is a cost of production, and I believe that we should stick with it. I believe that there has been some departure made already which has been detrimental. I don't know whether that is a very good answer to your question or not.

Senator MCCARTHY. We are glad to have your opinion on it in any case.

I have no more questions.

Thank you very much.

Mr. CALLAHAN. Thank you, sir.

Senator MCCARTHY. Mr. Frank Bane of the Advisory Commission on Intergovernmental Relations.

You may proceed.

STATEMENT OF FRANK BANE, CHAIRMAN, ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS; ACCOMPANIED BY WILLIAM G. COLMAN, EXECUTIVE DIRECTOR OF THE COMMISSION; AND PAGE T. INGRAHAM, STAFF MEMBER OF THE COMMISSION

Mr. BANE. Mr. Chairman, my name is Frank Bane, Chairman of the Advisory Commission on Intergovernmental Relations and I have

with me Mr. William Colman, Executive Director of the Commission, and Mr. Page Ingraham, who is a staff member of the Commission.

I appreciate the opportunity of appearing before your committee to present the views of the Advisory Commission on Intergovernmental Relations on H.R. 6675, the social security amendments of 1965.

The Advisory Commission was created by Public Law 380 of the 86th Congress as a bipartisan body of 26 members representing all levels of Government. It is charged with giving continuing study and attention to the relationships among the National, State, and local governments and with developing recommendations for improving these relationships.

Among the Commission's specific statutory responsibilities is that prescribed in section (3) of the act—giving "critical attention to the conditions and controls involved in the administration of Federal grant programs."

It was pursuant to this statutory mandate that the Commission undertook a study of the statutory and administrative controls associated with Federal Grants for public asistance. A copy of the Commission's report adopted in May 1964, is submitted herewith for the information of the committee.

Upon the completion of this study, which focused on the question of intergovernmental relations in the administration of the public assistance program, the Commission presented, for the consideration of the Congress, recommendations designed to overcome the main points of intergovernmental friction. These recommendations propose that the public assistance titles of the Social Security Act be amended to—

Provide judicial review of administrative decisions of the Secretary of Health, Education, and Welfare regarding the conformity of State plans under the act.

Remove the prohibitions against Federal Participation in public assistance payments to mental and tubercular patients.

Grant discretion to the Secretary of Health, Education, and Welfare to waive the "single State agency" requirement for the public assistance titles so that States could organize their administrative agencies in a manner compatible with their own needs so long as the program objectives of the act are not endangered.

Provide the Secretary of Health, Education, and Welfare with the discretion to declare parts of a State plan out of conformity with the Federal act, rather than have to reject the whole plan, because of the inadequacy of one part.

Establish a permanent Public Assistance Advisory Council to provide a voice for State and local advice to the Secretary of Health, Education, and Welfare on proposed legislation, administrative regulations, and other related matters.

We are gratified that provisions which will cary out the first two of these recommendations are included in H.R. 6675 as it is now before you. We urge the retention of these provisions in the bill. Attached to our statement is a summary of the reasons for their inclusion.

Suggested amendments to the public assistance titles of the Social Security Act to implement the three additional recommendations made by the Commission are incorporated in H.R. 6241, introduced by Congressman L. H. Fountain of North Carolina. We recommend that

H.R. 6675 be amended to include these provisions. Since I will refer to the appropriate sections in my comments, I would like to request that the text of H.R. 6241 appear as an attachment to this statement.

Senator MCCARTHY. That will be done.

(H.R. 6241 referred to follows:)

[H.R. 6241, 89th Cong., 1st sess.]

A BILL To amend the public assistance provisions of the Social Security Act to provide for judicial review of certain administrative decisions of the Secretary of Health, Education, and Welfare, to enable the Secretary to waive the "single State agency" requirement, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) title VII of the Social Security Act is amended by adding at the end thereof the following new section:

"JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

"SEC. 706. (a)(1) Whenever a State plan or an amendment to a State plan is submitted to the Secretary by a State for approval under title I, IV, X, XIV, or XVI of this Act he shall, not later than sixty days after the date the plan or amendment is submitted to him, make a determination as to whether it conforms to the applicable requirements of this Act. The sixty-day period provided herein may be extended but only by written agreement of the Secretary and the affected State.

"(2) Any State dissatisfied with a determination of the Secretary with respect to such a plan or amendment submitted for approval may, within thirty days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan or amendment conforms to the applicable requirements of this Act. 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 twenty days nor more than thirty 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 thirty days of the conclusion of the hearing.

"(3) Any State which is dissatisfied with a determination made by the Secretary on such a reconsideration of the issue of whether such plan or amendment conforms to the applicable requirements of this Act may appeal to the United States Court of Appeals for the circuit in which such State is located by filing with such court a notice of appeal. Summons and notice of appeal may be served at any place in the United States. The Secretary shall forthwith certify and file in the court the transcript of the proceedings and the record on which he based his action.

"(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 decision 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 of the United States Code.

"(b) Any determination of the Secretary that a State plan approved under title I, IV, X, XIV, or XVI does not comply with the applicable provisions of this Act, or that in the administration of such plan there is a failure to comply substantially with any such provision, shall be subject to review as provided in subsection (a).

"(c) In any case where a determination of the Secretary under subsection (a)(1) or (b) would, in the absence of specific or further action by the State, result in—

"(1) loss of the State's eligibility for payments to which it had theretofore been entitled under the program involved or reduction in the amount of such payments, or

"(2) inability of the States to become eligible for payments or for increased payments under the program involved, where such payments or increased payments have been made generally available to the States which qualify therefor, under such program,

the State may secure by declaratory judgment proceedings pursuant to section 10 of the Administrative Procedure Act (5 U.S.C. 1009) a decision (A) as to whether the plan or amendment involved conforms to the applicable requirements of this Act (in the case of a determination made under subsection (a)(1)) or whether there is a failure to comply with the applicable provisions of this Act, and (B) as to the effect of the nonconformity or noncompliance, if any, on the State's continued participation in the program involved.

"(d) Any judicial proceeding pursuant to this section shall be entitled to, and upon request of the Secretary or the State shall receive, a preference, and shall be heard and determined as expeditiously as possible.

"(e) Any notice of appeal by a State to a court of appeals pursuant to this section shall be filed with such court within thirty days from the date of the determination of the Secretary from which such appeal is to be taken."

(b) The amendment made by subsection (a) shall apply only with respect to determinations made by the Secretary of Health, Education, and Welfare (as described in subsections (a)(1) and (b) of section 706 of the Social Security Act, as added by such amendment) on and after the date of the enactment of this Act.

SEC. 2. (a) Title VII of the Social Security Act is amended by adding at the end thereof (after the new section added by the first section of this Act) the following new section:

"WAIVER OF SINGLE STATE AGENCY REQUIREMENT

"SEC. 707. Notwithstanding section 2(a)(3), 402(a)(3), 1002(a)(3), 1402(a)(3), or 1602(a)(3), the Secretary may, upon request of the Governor or other appropriate executive or legislative authority of the State involved, waive (with respect to such State) the requirement of such section that the plan of such State approved under title I, IV, X, XIV, or XVI (as the case may be) must provide that a single State agency be established or designated to administer or supervise the administration of such plan (or, in the case of title XVI, to administer or supervise the administration of the portion of the plan not relating to blind individuals), and may instead approved another administrative structure or arrangement if he determines that the objectives of such title will not be endangered by the use of such other structure or arrangement."

(b) Sections 2(a)(3), 402(a)(3), 1002(a)(3), 1402(a)(3), and 1602(a)(3) of such Act are each amended by striking out "either provide" and inserting in lieu thereof "subject to section 707, either provide".

SEC. 3. (a) Section 4 of the Social Security Act is amended to read as follows:

"OPERATION OF STATE PLANS

"SEC. 4. If the Secretary, after reasonable notice and opportunity for hearing to the State agency (or agencies) 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 2, or

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

the Secretary shall notify such State agency (or agencies) that further payments will not be made to the State (or, in his discretion, that payments will be limited to 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 make no further payments to such State (or shall limit payments to parts of the State plan not affected by such failure)."

(b) Section 404(a) of such Act is amended to read as follows:

"(a) If the Secretary, after reasonable notice and opportunity for hearing to the State agency (or agencies) 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 402; or

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

the Secretary shall notify such State agency (or agencies) that further payments will not be made to the State (or, in his discretion, that payments will be limited to 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 make no further payments to such State (or shall limit payments to parts of the State plan not affected by such failure)."

(c) Section 1004 of such Act is amended to read as follows:

"OPERATION OF STATE PLANS

"SEC. 1002. If the Secretary, after reasonable notice and opportunity for hearing to the State agency (or agencies) 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 1002; or

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

the Secretary shall notify such State agency (or agencies) that further payments will not be made to the State (or, in his discretion, that payments will be limited to 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 make no further payments to such State (or shall limit payments to parts of the State plan not affected by such failure)."

(d) Section 1404 of such Act is amended to read as follows:

"OPERATION OF STATE PLANS

"SEC. 1404. If the Secretary, after reasonable notice and opportunity for hearing to the State agency (or agencies) 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 1402; or

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

the Secretary shall notify such State agency (or agencies) that further payments will not be made to the State (or, in his discretion, that payments will be limited to 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 make no further payments to such State (or shall limit payments to parts of the State plan not affected by such failure)."

(e) Section 1604 of such Act is amended by inserting "(or agencies)" after "State agency" each place it appears.

SEC. 4. (a) Subsections (a), (b), and (c) of section 1114 of the Social Security Act are amended to read as follows:

"(a) In administering titles I, IV, X, XIV, and XVI of this Act, the Secretary shall consult with a Public Assistance Advisory Council consisting of the Secretary (or his designated represenative), who shall serve as Chairman ex officio, and eight members appointed by the Secretary. It shall be the purpose of the Council to advise the Secretary in the performance of the functions and duties vested in him in connection with the public assistance programs under such titles, and particularly to assist the Secretary in ascertaining the impact, on State and local government administration of such programs, of the provisions of (1) any regulations which the Secretary proposes to issue regarding such administration and (2) any new legislation which the Secretary proposes to recommend with respect thereto. The Council may make such recommendations to the Secretary as it deems appropriate.

"(b) The Council shall be initially appointed by the Secretary not later than July 1, 1966. The members shall be appointed without regard to the civil service laws. Four of the eight appointed members shall be representatives of State agencies concerned with the administration of the public assistance programs (and at least one of them shall represent a State agency which is concerned with a State-supervised, locally-administered public assistance program); two of the members shall represent county or municipal agencies concerned with the administration of the public assistance programs; and the other two members shall be persons with special knowledge, experience, or qualifications with respect to such programs. Each appointed member shall hold office for a term of four 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 the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year, and two at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served immediately preceding his reappointment. The Council shall meet as frequently as the Secretary deems necessary, but not less than once each year. Upon request by three or more members, it shall be the duty of the Secretary to call a meeting of the Council.

"(c) The Secretary shall make available to the Council such secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health, Education, and Welfare as the Council may require to carry out its functions."

(b) Effective July 1, 1966, subsection (d) and (e) of section 1114 of such Act are repealed and subsections (f), (g), and (h) are redesignated (d), (e), and (f), respectively.

Mr. BANE. Section 2 of H.R. 6241 permits the waiver of the "single State agency" requirement. This requirement is based larely on a historical situation that has little relevance today and has become a matter of controversy in a number of States. I recall that during my service as the first executive director of the old Social Security Board some States did not then have a welfare department or comparable agency to handle public assistance programs.

For that reason, in the initial years, the single State agency requirement served to introduce an element of order into State administration of the emerging programs. It also provided one agency as a single point of contact that the Federal agency could deal with in administering its program.

At present, however, public assistance programs are well established and the States are fully experienced in their administration.

The rigid single State agency requirement imposes undue restrictions on the States in their efforts to organize the executive branch of State government in the most efficient manner.

The Governors' conference has been particularly concerned with this problem and, following a study of the impact of these restrictions on States, adopted a resolution at its 53d annual meeting in 1961, which stated that—

* * * the conference deplores the tendency of Federal agencies to dictate the organizational form and structure through which the States carry out federally supported programs.

Section 2 of H.R. 6241, in permitting the waiving of the single State agency requirement, upon the request of the Governor or other appropriate executive or legislative authority in a State, fully protects national objectives by providing that the Secretary can waive the requirement if he finds that it will not adversely affect his own program.

Another element of inflexibility in the administration of the Federal public assistance program is the lack of authority for the Secretary to find parts of a proposed State plan not in conformity with the requirements of the act. At present, even if a separable part of a plan is all that is in question, the whole plan must be found out of conformity.

Title XVI of the Social Security Act adopted in 1962 provides for the development of a combined plan of aid to the aged, blind, or dis-

abled. It specifically authorizes the the Secretary to find only part of a plan out of conformity, if that is the case.

Section 3 of H.R. 6241 gives the Secretary similar discreation under the other public assistance titles to withhold payments only for those parts of a State plan not in conformity. In addition to providing flexibility, such a provision would also simplify the judicial review process by limiting the portion of a plan which would become involved in litigation.

Finally, in order to provide a more effective mechanism through which State and local officials can have a voice in the formulation of Federal legislative proposals and the development of administrative requirements, our Commission has recommended that a permanent Public Assistance Advisory Council be established.

Although temporary advisory groups have been appointed from time to time and although State and local officials are consulted by the Secretary, such a Council would facilitate intergovernmental cooperation in this important field.

S. 1891, now before your committee, and section 4 of H.R. 6241 make a similar provision for such a Council.

It is the Advisory Commission's opinion that, if legislation is enacted incorporating these five provisions, a number of sources of friction between the Federal Government and the States and local government will be eliminated, while cooperative administration of these grant-in-aid programs will be facilitated. We therefore urge their adoption by the committee and the Congress.

Thank you very much for this opportunity.

(The attachments referred to follow:)

ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, MAY 19, 1965, COMMENTS ON SECTIONS 221 AND 404 OF H.R. 6675

JUDICIAL REVIEW OF DETERMINATIONS OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE REGARDING STATE PLANS FOR PUBLIC ASSISTANCE

At present, States have no appeal from decisions of the Secretary of Health, Education, and Welfare declaring a State plan out of conformity with the Social Security Act. The Advisory Commission, in recommending provisions for judicial review, expressed the feeling that the lack of such an ultimate recourse tends to hamper initiative on the part of the States and thus the development of new approaches in the administration of public welfare programs. There is ample precedent for judicial review in this type of program since there are such provisions in at least 12 other present grant-in-aid programs administered by the Secretary of Health, Education, and Welfare, as summarized in the attachment hereto. In several instances, the provisions were included in legislation recommended by the administration, as indicated in the attachment.

PUBLIC ASSISTANCE ELIGIBILITY OF MENTAL AND TUBERCULAR PATIENTS

Under the present provisions of the public assistance title of the Social Security Act, Federal matching funds are not available for patients in general medical institutions as a result of a diagnosis of psychosis or tuberculosis or those in specialized mental or tuberculosis institutions, except that Federal matching is available for up to 42 days for the care of such patients in general medical institutions. In making its recommendation for the removal of such restrictions, the Commission felt that, particularly in the light of current medical practice, Federal matching should be available for needy mental and tubercular patients as it is to other public assistance recipients. Furthermore, there is increasing emphasis on the treatment of mental patients to the extent possible in general medical institutions near their homes. This approach to treatment may include the transfer of patients in mental institutions to general

medical institutions when the condition of the patient permits. The present prohibitions in the act discourage such treatment. In fact, the 42-day limitation may result in the transfer of patients from general medical institutions to mental institutions, even though the patient's condition does no necessitate such a transfer.

PROVISIONS OF FEDERAL GRANT-IN-AID PROGRAMS HAVING JUDICIAL REVIEW OF ADMINISTRATIVE RULINGS

Program: Grants to States for practical nurse training.
Citation and language: 20 U.S.C. 15cc(d).

(d) (1) If any State is dissatisfied with the Commissioner's action under subsection (c) of this section, such State may appeal to the United States court of appeals for the circuit in which the State is located. The summons and notice of appeal may be served at any place in the United States.

(2) The findings of fact by the Commissioner, 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 Commissioner to take further evidence, and the Commissioner may thereupon make new or modified findings of fact and may modify his previous action. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

(3) The court shall have jurisdiction to affirm the action of the Commissioner 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 * * *.

Litigation: None.
Program: Area vocational education.
Citation and language: 20 U.S.C. 15eee(d).
Language same as practical nurse training program above.
Litigation: None.
Program: Vocational education (administration recommendation).
Citation and language: Public Law 88–210, section 5(d).

(d) A State board which is dissatisfied with a final action of the Commissioner under subsection (b) or (c) may appeal to the United States court of appeals for the circuit in which the State is located, by filing a petition with such court within sixty days after such final action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Commissioner, or any officer designated by him for that purpose. The Commissioner thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Commissioner or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record the Commissioner may modify or set aside his action. The findings of the Commissioner as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Commissioner to take further evidence, and the Commissioner may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Commissioner shall be final, 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. The commencement of proceedings under this subsection shall not, unless so specifically ordered by the court, operate as a stay of the Commissioner's action.

Litigation: None.
Program: Public library services for rural areas.
Citation and language: 20 U.S.C. 356.

If the Commissioner finds after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this chapter, that the State plan has been so changed that it no longer complies with the requirements of this chapter or that in the administration of the plan there is a failure to comply substantially with the provisions required to be included in the plan, he shall notify such State agency that further payments will not be made to the State under this chapter until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State: *Provided*, That any State or State agency is entitled to judicial review in the United States district court wherein the State or State agency is located of any such withholding determination in accordance with applicable provisions of the Administrative Procedures Act. (June 19, 1956, c. 407, 7, 70 Stat. 295.)

Litigation: None.

Program: Library services and construction (administration recommendation).

Citation and language: Public Law 88–269, section 8.

(d) (1) The Commissioner shall not finally disapprove any State plan submitted under this Act, or any modification thereof, without first affording the State submitting the plan reasonable notice and opportunity for a hearing.

(2) If any State is dissatisfied with the Commissioner's final action with respect to the approval of its State plan submitted under title I or title II, or with respect to his final action under section 301, such State may appeal to the United States court of appeals for the circuit in which the State is located, by filing a petition with such court within sixty days after such final action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Commissioner or any officer designated by him for that purpose. The Commissioner thereupon shall file in the court for the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code.

(3) Upon the filing of the petition referred to in paragraph (1) of this subsection, the court shall have jurisdiction to affirm the action of the Commissioner or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record the Commissioner may modify or set aside his order. The findings of the Commissioner as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Commissioner to take further evidence, and the Commissioner may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(4) The judgment of the court affirming or setting aside, in whole or in part, any action of the Commissioner shall be final, 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. The commencement of proceedings under this subsection shall not, unless so specifically ordered by the court, operate as a stay of the Commissioner's action.

Litigation: None.

Program: National defense education.

Citation and language: 20 U.S.C. 585.

(a) If any State is dissatisfied with the Commissioner's final action with respect to the approval of its State plan submitted under this Act, or with respect to his final action under section 584(c) of this title, such State may, within sixty days after notice of such action, file in the United States district court for the district in which the capital of the State is located, a petition to review such action. The petition for review shall (1) contain a concise statement of the facts upon which the appeal is

based, and (2) designate that part of the Commissioner's decision sought to be reviewed.

(b) Notification of the filing of the petition for review shall be given by the clerk of the court by mailing a copy of the petition to the Commissioner.

(c) No costs or docket fees shall be charged or imposed with respect to any judicial review proceedings, or appeal therefrom, taken under this Act.

(d) Upon receipt of the petition for review the Commissioner shall, within twenty days thereafter, certify and file in the court the record on review, consisting of the complete transcript of the proceedings before the Commissioner. No party to such review shall be required, by rule of court or otherwise, to print the contents of such record filed in the court.

(e) The court after review may dismiss the petition or deny the relief prayed for, or may suspend, modify, or set aside, in whole or in part, the action of the Commissioner, or may compel action unlawfully withheld. The judgment of the court shall be subject to review as provided in sections 1291 and 1254 of title 28. (Public Law 85–864, title X, 1005, Sept. 2, 1958, 72 Stat. 1604.)

Litigation: None.

Program: School construction in areas affected by Federal activities.

Citation and language: 20 U.S.C. 641.

(a) Whenever the Commissioner of Education, after reasonable notice and opportunity for hearing to a local educational agency, finds (1) that there is a substantial failure to comply with the drawings and specifications for the project, (2) that any funds paid to a local educational agency under this chapter have been diverted from the purposes for which paid, or (3) that any assurance given in an application is not being or cannot be carried out, the Commissioner may forthwith notify such agency that no further payment will be made under this chapter with respect to such agency until there is no longer any failure to comply or the diversion or default has been corrected or, if compliance or correction is impossible, until such agency repays or arranges for the repayment of Federal moneys which have been diverted or improperly expended.

(b) The final refusal of the Commissioner to approve part or all of any application under this chapter, and the Commissioner's final action under subsection (a) of this section, shall be subject to judicial review on the record, in the United States court of appeals for the circuit in which the local educational agency is located, in accordance with the provisions of the Administrative Procedure Act. (Sept. 23, 1950, c. 995, 11, as added Aug. 12, 1958, Public Law 85–620, title I, 101, 72 Stat. 554.)

Litigation: One case, *School City of Gary* v. *Derthick* (C.A. 7, 1959), 273 F. 2d 319.

Program: Vocational rehabilitation service for persons injured in industry programs.

Citation and Language: 29 U.S.C. 35(d).

(d) If any State is dissatisfied with the Secretary's action under subsection (c) of this section, such State may appeal to the United States district court for the district where the capital of such State is located and judicial review of such action shall be on the record in accordance with the provisions of the Administrative Procedure Act.

Litigation: None.

Program: Construction of hospitals and other facilities.

Citation and language: 42 U.S.C. 291j(b).

(d) If any State is dissatisfied with the Secretary's action under subder section 291h or 291v of this title, the State agency through which the application was submitted, or if any State is dissatisfied with the Surgeon General's action under subsection (a) of this section, such State may appeal to the United States court of appeals for the circuit in which such State is located. The summons and notice of appeal may be served at any place in the United States. The Surgeon General shall forthwith certify and file in the court the transcript of the proceedings and the record on which he based his action.

(2) The findings of fact by the Surgeon General, 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 Surgeon General to take further evidence, and the Surgeon General 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.

(3) The court shall have jurisdiction to affirm the action of the Surgeon General 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 sections 346 and 347 of title 28.

Litigation: None.

Program: Higher education facilities.

Citation and language: Public Law 88-204, section 111.

SEC. 111. (a) If any State is dissatisfied with the Commissioner's final action with respect to the approval of its State plan submitted under section 105(a) or with his final action under section 110(b), such State may appeal to the United States court of appeals for the circuit in which such State is located. The summons and notice of appeal may be served at any place in the United States. The Commissioner shall forthwith certify and file in the court the transcript of the proceedings and the record on which he based his action.

(b) The findings of fact by the Commissioner, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Commissioner to take further evidence, and the Commissioner 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 if supported by substantial evidence.

(c) The court shall have jurisdiction to affirm the action of the Commissioner 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 title 28, United States Code, section 1254.

Litigation: None.

Program: Mental retardation facilities and community mental health centers construction (administration recommendation).

Citation and language: Public Law 88-164, section 404.

SEC. 404. If the Secretary refuses to approve any application for a project submitted under section 135 or 205, the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 134(b) or 204(b) or section 136 or 206, such State, may appeal to the United States court of appeals for the circuit in which such State is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial 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 file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, 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. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

Litigation: None.

Program: Financial assistance to elementary and secondary education (administration recommendation).
Citation and language: Public Law 89-10, section 207.

((a) If any State is dissatisfied with the Commissioner's final action with respect to the approval of its State plan submitted under section 203(a) or with his final action under section 206(b), such State may, within sixty days after notice of such action, file with the United States court of appeals for the circuit in which such State is located a petition for review of that action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Commissioner. The Commissioner thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code.

(b) The findings of fact by the Commissioner, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Commissioner to take further evidence, and the Commissioner may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(c) The court shall have jurisdiction to affirm the action of the Commissioner 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.

Senator McCarthy. Thank you very much, Mr. Bane. I appreciate your coming to testify.

I have no questions, Mr. Bane.

Dr. William Camp, of the National Association of State Mental Health Program Directors.

STATEMENT OF DR. WILLIAM CAMP, COMMISSIONER OF MENTAL HEALTH, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, REPRESENTING THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Dr. Camp. Mr. Chairman, I appear before your committee this morning on behalf of my colleagues, the directors of programs for the mentally ill in the 50 States and the territories, to present facts which we hope will persuade your committee to eliminate a discriminatory provision in H.R. 6675, as passed by the House of Representatives.

However, before I discuss the one provision we consider to be discriminatory against the mentally ill aged, I wish to acknowledge the many provisions in the bill that are beneficial to the mentally ill and retarded.

For the mentally ill and retarded this is a landmark bill, in spite of its severe discrimination in title I.

We were especially gratified to see the House adopt and incorporate in H.R. 6675 what we in the States have been calling for several years the "Long-Carlson amendment." This provision (pt. 3 of title II) removes the longtime exclusion of public mental hospitals as recipients of Federal old-age-assistance benefits for treatment of the aged.

For years we have supported the often lonely fight made on this issue by two of your most distinguished committee members, who over many years and in many instances, back home in their States, and here in Washington, have proven to be genuine friends of sufferers from mental illness—Senator Russell Long, of Louisiana, and Senator Frank Carlson, of Kansas.

We also note with gratification the extension of grants for implementation of mental retardation planning. In most States this, too, is a program administered by our members.

Another outstanding feature of H.R. 6675 is part I of title II which provides $325 million in new grant money for various child-care programs, including mentally retarded children.

In all, this is truly an outstanding piece of proposed legislation as far as the mentally ill and retarded are concerned.

We do, however, come before you with one grave reservation, which we hope in the wisdom of this committee will be corrected.

I speak of the discriminatory language on page 24 of the bill, which prohibits benefits to aged persons treated in a mental hospital.

Mr. Chairman, my initial statement will be brief and I hope you will put questions to me, reflecting whatever doubts exist in the minds of the committee members, so that I may have an opportunity to dispel in open discussion whatever unspoken or unwritten suspicion exist concerning treatment of the mentally ill aged in mental hospitals.

I say "unspoken or unwritten" because, while payment for care of the mentally ill aged in a mental hospital is specifically forbidden under part A of the "Health Insurance" section ("Hospital Insurance Benefits for the Aged") we can thus far find no statement, no facts, no argument by either branch of Congress in justification of such discriminatory action.

We find only that, in lieu of coverage in the logical place in the bill—that is part A—"Hospital Insurance Benefits"—limited benefits are allowed for treatment of a mentally ill aged person in a mental hospital in another part of the bill. We find that mental hospital benefits are available only if an aged person has signed up for the "Voluntary Supplementary Plan" (pt. B).

Thus, under part B, for $3 a month out of his pocket the aged person gets a limited amount of mental hospital protection. Whereas, at no cost, he gets extensive hospital coverage under part A for any organic illness; that is, any illness that is not mental.

The House of Representatives, neither in its committee report nor in floor debate, saw fit to explain the reason for these severely restricted benefits and discriminatory action against the mentally ill aged.

Unlike your action, Mr. Chairman, when the directors of State mental health programs petitioned the House committee for an opportunity to appear and present the facts on mental hospital treatment of the aged, that request was denied.

Thus we come before you today with our first opportunity to raise the question of discrimination against the mentally ill in H.R. 6675, but without knowing the congressional basis for this discrimination.

We can only ask, in view of the foregoing, that the discrimination be removed.

It is our recommendation that your committee delete from H.R. 6675 the language beginning on line 24 of page 66—"Notwithstanding the preceding": * * * and so forth, and ending on line 8 of page 67.

The foregoing language is a sentence that discriminates against the mentally ill by excluding from the definition of "Hospital" (sec. 1861(e)), "any institution which is primarily for the care and treatment of mental diseases * * * ."

Mr. Chairman, let's review several sets of facts in connection with treatment of the mentally ill aged in public mental hospitals.

1. The 278 State mental hospitals, supervised by the members of our association, treat more mentally ill aged than any other hospital system in the country—perhaps the world.

2. It is not true—despite long-held notions—that the mentally ill aged cannot be quickly (within 30 to 60 days) restored to family and community. They can.

3. It is not true that in our State mental hospitals today a newly admitted aged person is most likely to spend the rest of his life in that hospital.

4. It is a fact that when the dollars and personnel are available and the aged mentally ill are submitted to intensive treatment they respond in almost the same proportions as persons of other ages.

5. It is also a fact that in many of our State hospitals we are caring for aged who do not belong there.

Many of the aged cared for in State hospitals are not, strictly speaking, "mentally ill." Frequently they are persons who need medical attention—but not necessarily in a mental hospital. These persons can be treated or cared for in specialized geriatric facilities. We are not proposing that benefits be available under part A ("Hospital Insurance Benefits") for treatment of persons who do not belong in public mental hospitals.

Now, having established certain premises (on which I would be most happy to have you interrogate me) let me take a moment to discuss with you just two or three typical programs in the States for care of the mentally ill aged.

In Baton Rouge, La., the Baton Rouge Mental Health Center, under the direction of Dr. Bill Addison, has under active treatment an average of 80 to 120 aged mentally ill. Many of these persons are severely psychotic.

Few of these persons ever become hospitalized as inpatients (that is, requiring 24-hour bed care).

On an average Dr. Addison may have to send five or six of these patients into full-time hospital care. The others are treated within 60 days and live at home.

The important point here is that the aged mentally ill treated at Dr. Addison's center respond to intensive treatment in the same proportion as 43-year-olds or 28-year-olds.

They do not automatically become "custodial" cases as so many ill-informed people suppose.

The same kind of evidence can be obtained at Southeast Louisiana State Hospital (at Mandeville, La.), where Dr. Tom Fulmer provides intensive treatment for the aged mentally ill and gets them back to their homes in New Orleans as fast as patients 30 years younger. The concept that mentally ill persons should be discriminated against because they are "aged" is incomprehensible to these two distinguished State hospital physicians.

Here is a verbatim report from the director of the Department of Mental Health for the State of Oklahoma describing a new program he has initiated for mentally ill aged in two of his State hospitals. This brief report, by Albert Glass, M.D., was prepared especially for submission before your committee.

At two of our hospitals, we have established—

this is quoting from Dr. Glass—

intensive diagnostic and treatment units for admissions who are 65 years and older.

These patients represent, by and large, a mixture of the physical disease aspects of growing old, and the psychological—usually depressive—aspects of aging, and the socioeconomic difficulties involved in the aging process.

We have found that if a strong effort is made, particularly to hold on to the family and accomplish remedial work on patients such as relief of malnutrition, anemia, cardiac decompensation, control of diabetes, removal of cataracts, or any other amelioration of disease, many of these patients can be returned to their homes within a 3-month period.

At times, if surgery is needed, the time period may be somewhat longer—4 or 5 months.

A number of the elderly patients have such severe physical illness; that is, vascular disease of the brain, heart, etc., that they require mainly physical nursing care. These patients are referred to nursing homes in their community.

A time difficulty is often involved in many of these cases because they or their families are unable to afford a private nursing home. For this reason, such cases are submitted to the department of public welfare for eligibility under old-age assistance which requires a good deal of time.

In both of these pilot projects, if we could have eliminated the time difficulty of placement in nursing homes, three-fourths of total admissions could be discharged from the hospital either to their own homes or to nursing homes within the 3-month period.

In a few instances, death occurred within the first 3 months.

In brief—

and this is Dr. Glass of Oklahoma speaking—

it is our firm belief that 75 percent of geriatric admissions, either because of active treatment and/or nursing home placement, could leave the State mental hospitals within a 3-month period.

In a report made only a few days ago the Mental Health Commissioner for North Carolina, Eugene Hargrove, M.D., focused on the very problem we are discussing here today—that is: discrimination against the mentally ill aged.

Dr. Hargrove says:

Many of the geriatric population do not really belong in a State psychiatric hospital. They are not mentally ill. * * *

He calls these patients "misplaced persons."

Dr. Hargrove then makes the point that with more improved medical and neurological evaluation of in-coming geriatric patients and with more improved intensive care treatment and rehabilitation programs for the aged it is possible to drastically reduce the length of stay of aged patients in mental hospitals.

Dr. Hargrove cites the new treatment programs at Dorothea Dix State Hospital at Raleigh, N.C., and how they have speeded up the return of aged persons to their homes and communities.

Dr. George Ulett, the Director of the Division of Mental Disease for the State of Missouri, reports that at the Malcolm Bliss Mental Health Center, which is a State hospital in St. Louis, the average stay of patients over 65 years of age has been 44 days.

These patients had been provided intensive treatment.

Mr. Chairman, each of the 50 States could tell you in great detail of its programs for successful treatment of the mentally ill aged. Because of my time limitations I have cited only a few.

Every State is making enormous progress in this direction—all the more reason why we should not be discriminated against in H.R. 6675.

First of all—giant steps are being made everywhere to shift from State mental hospitals the geriatric patients who do not belong there, but who are now there for a multitude of reasons that have little to do with mental illness.

For example: a recent study by the Mental Health Department in the State of Georgia showed that, out of 3,048 aged State mental hospital patients, 1,220 should be in nursing homes or specialized geriatric hospitals. They are not mentally ill.

The old notion that a State mental hospital provides custodial care for aged persons with a variety of physical and social problems is passé. The States all acknowledge this.

And this notion should not be perpetuated by a discriminatory provision in part I(a) of title I of H.R. 6675.

Second—in the State mental hospital programs great strides are being taken to provide intensive treatment for aged who are mentally ill.

And where this is being done the aged are being returned to their communities, their homes, their jobs with the same speed as any other age group.

Again, this is a reason not to discriminate against treatment of these people.

It is our estimate that the aged can be given intensive treatment in the State mental hospital programs for $17 per day.

In the case of an intensive day treatment program like that run by the Baton Rouge Mental Health Center, where very few of the aged persons ever receive inpatient treatment, the cost would average a few dollars a day.

Each year there are 27,000 first admissions of persons over 65 years of age to State mental hospitals.

If each one of these new admissions were eligible for benefits under H.R. 6675 and were treated and discharged after 44 days—the average treatment period at the Malcolm Bliss State facility in St. Louis, Mo.—then the cost would be $748 per patient, or $20 million for all the mentally ill aged new admissions to State hospital in 1 year. However, low as that figure is—compared to the estimated $2 billion for the "Hospital insurance" or "Basic plan" program in 1967—the actual cost of coverage will be much lower.

The reason for this is: Under section 1861 (pp. 67-68) of H.R. 6675, "Definition of Services," eligible patients can be treated only in hospitals accredited by the Joint Commission on Accreditation of Hospitals. In the United States there are only 85 public mental hospitals "accredited" with a total of 215,235 beds.

The cost figure I just cited was based on the total number of public mental hospitals in the United States—275—with about 500,000 beds. However, 27 States do not have any accredited public mental hospitals, and most other States are only partially accredited at this time.

Thus, under the most liberal estimates, it is unlikely that the expenditures under part I(A) for treatment of the aged—mentally ill in public mental hospitals, would exceed $10 million annually.

Mr. Chairman, this is not an excessive figure when compared to the whole program you are considering.

Mr. Chairman, we have presented here certain facts and evidence which we hope will be given sympathetic attention by your committee.

Perhaps in its wisdom your committee will, as a result, perceive that H.R. 6675, as it now stands discriminates without justification against one group of sick aged—that is the mentally ill.

The mentally ill aged are being successfully treated and rapidly returned to their homes. And they are so being beneficially treated in public mental hospitals.

The cost of such treatment will not be an excessive addition to the hospital insurance program.

For these reasons, we hope that you will strike from H.R. 6675 the unfair language contained in lines 24 and 25 on page 66 and lines 1 through 8 on page 67.

That concludes my statement for the National Association of State Mental Health Program Directors.

Mr. Chairman, with your permission, I would like to introduce a sheet of interesting material from the State of Delaware bearing on this same question into the record. I will not read this material, but it shows that the average hospital stay in mental hospitals as reflected in Blue Cross claims for mental and nervous illnesses in Delaware in 1964 was 41.7 days for the aged 65 to 74, and only 36.8 days for the aged 75 and up.

Thank you, Mr. Chairman, very much.

(The information referred to follows:)

Delaware Blue Cross mental/nervous claims by type of institution, 1964, incurred, all certificates

	Number of cases	Percent of total	Actual stay	Percent in mental institution; in general hospital
1. In mental institutions:				
Age class:				
24	56	11.7	41.8	.....
25 to 34	80	16.7	40.3	.....
35 to 44	115	24.1	41.5	.....
45 to 54	103	21.5	40.6	.....
55 to 64	62	13.0	44.6	.....
65 to 74	34	7.1	41.7	.....
75 and up	28	5.9	36.8	.....
Total	478	100.0	41.3	49.3
2. In general hospitals: Total	492	.....	.....	50.7
3. In all institutions	970	.....	.....	100.0

Senator McCarthy. Senator Douglas?

Senator Douglas. No questions.

Senator McCarthy. The estimates that you give are the number of beds in public mental hospitals.

Do you have any estimates or count as to the number of beds that might be available in nonpublic mental hospitals or are none of them accredited?

Dr. Camp. No; several of them are accredited. I cannot give you the figure today, Mr. Chairman.

Of course, it is very, very much lower than that.

Senator McCarthy. I assume there are two reasons for this exclusion: one, the costs and the other the fact, as you say, that 27 States do not have an accredited mental hospital. I suppose those same States probably do not have accredited nonpublic or private hospitals.

Dr. CAMP. That is largely true.

Senator MCCARTHY. I assume this would be the reason for providing benefits for the aged mentally ill person in half the States and not in the other half of the States.

Dr. CAMP. Quite possible.

Senator MCCARTHY. Thank you very much.

Dr. CAMP. Thank you.

Senator MCCARTHY. Mr. Paul Barnhart.

All right, you may proceed.

STATEMENT OF PAUL BARNHART, CONSULTING ACTUARY

Mr. BARNHART. Mr. Chairman, and Senator Douglas, my name is E. Paul Barnhart of St. Louis, Mo. I am an independent health insurance actuary known nationally as a professional expert in the health insurance field.

I render actuarial services both to insurance carriers and also to consumers, such as labor unions and employee welfare plans.

I am not here to testify as a representative of the health insurance business, or of any other specific interest; the people I seek to represent are millions of Americans who are already protected under lifetime health insurance programs of one kind or another.

I am convinced, after careful analysis of H.R. 6675, that unless amendments are made in this bill, it will cause massive harm and injustice to millions of Americans who are now covered by lifetime voluntary plans. Let me be quite clear that I do not testify in opposition to the bill as such; my purpose is rather to urge your consideration of certain amendments which, in my professional judgment, will correct serious defects in the bill as now written.

H.R. 6675 will seriously damage the legal rights and equities which millions of Americans have acquired in private health insurance plans, operating as a penalty on the prudence of all these people.

The reason for this is that duplication of existing hospital and medical expense protection will be created on a mammoth scale by the enactment of the bill. Not only does this represent a fantastic public waste, but it will cause actual harm of massive dimensions. If our Nation is to achieve the goals our President has set before it, it cannot afford such vast waste and damage.

First, the bill threatens to destroy the very real financial equity that every person has who has owned, for several years, a lifetime guaranteed health policy with premium rates based on his original age of purchase. This is a real equity, which can be roughly measured by the difference in the rate still being paid, based on the policyholder's original age, and the premium that would be payable if the person bought the same plan today, at his present age.

Let me illustrate, using the rates of an actual comprehensive lifetime plan which pays benefits up to as high as $20,000, after deductible, for almost any kind of necessary medical expense and is guaranteed renewable for life.

For a man and wife at the husband's age 25, the cost of this plan is $9.85 monthly, about $5 monthly for each person.

At original age 50 it becomes $20.08, about $10 monthly for each person.

At original age 65 the rate is $27.81, about $14 monthly for each person. By the time the husband reaches 65, therefore, a couple who bought their insurance at age 50 have acquired an equity which is worth, each and every month, the difference as compared to issue age 65, or about $8 per month; more than $90 every year. For a husband originally age 25 at time of purchase, the equity by the time he attains age 65 is worth $18 each month, or more than $215 every year.

H.R. 6675 jeopardizes the legal guarantees and financial equities of these millions of policyholders, because it forces them either to abandon policies in which they have faithfully invested premium payments, many of them for years, or else to continue payment for policies which are in large measure duplicated by a Federal program.

Many of these people have comprehensive coverage which is easily superior to the benefits provided under the bill. If these Americans are forced to abandon these voluntary plans, they can only revert to a Federal plan that will give less protection than they already have. Nearly all comprehensive plans cover private nursing, drugs, and medicines outside the hospital, and go far beyond the 60 days of hospitalization provided under the bill.

Many plans provide a 100-percent rate of coverage for surgical and medical expenses, which are to be covered only at an 80-percent rate by the supplementary plan in the bill. Many plans apply no deductible to hospital expenses, which under the bill will be subject to a $40 deductible, or to doctor benefits, which under the bill are to be subject to a $50 deductible.

Wholesale abandonment of such existing voluntary programs will not represent social progress. It will be the worst kind of social regression, all the more distasteful because it is unnecessary.

Consider further the gross inequity that results from the fact that the bill ignores these millions of lifetime policies. As I've said, no allowance is made in the bill for the substantial equity these people have accumulated in their contracts. It does the same thing for them that it does for the person who has never invested one cent in health insurance. This is manifestly unfair. Let me draw an outrageous parallel.

Suppose I have deposited $20 every month in a savings account and have now saved $2,000. My neighbor, Mr. Jones, has never saved a penny. Then Congress enacts a law which confiscates every dime of my savings account. But I am told to relax, because the Government will now deposit $1,500 back into my account and also set up a $1,500 account for Mr. Jones. I am told I have not been hurt; instead Mr. Jones has been helped.

The injustice of this absurd arrangement is obvious, and the American public would be outraged at such a law. Yet this is exactly the sort of inequity that the bill creates. Equities built up through years of premium payments under individual lifetime policies are rendered worthless, while everyone age 65 or over is offered the same Federal plan on the same terms, in many instances less comprehensive than what is so unjustly replaced.

A similar situation exists for persons covered under lifetime retirement provisions of group policies. Some months ago I developed such a plan for the employees of a large Texas corporation. They now enjoy comprehensive retirement medical coverage, broader by far than

H.R. 6675, at a monthly cost of only $2.50. These people gain nothing from the bill, because it would cost them $3 per month just to enroll for the supplementary plan. And what about their employer? He is voluntarily shouldering most of the cost, but this bill offers him no relief at all from the additional taxes he must pay for a duplicating though less adequate, Federal plan.

The vast duplication which the bill will create is in direct conflict with the progress made by the States in combating wasteful duplication which enables many persons to profit from multiple coverage. New model antiduplication legislation has recently been developed by the National Association of (State) Insurance Commissioners. But if H.R. 6675 becomes law, without some changes, the Federal Government itself will more than undo all that the States have gained, creating overnight the most extensive duplication of coverage we've ever seen.

The bill is tragically at fault in completely and unjustly ignoring the contractual, legal rights and equities that more than 50 million Americans of all ages have in insurance contracts providing some kind of lifetime benefits. It is a duty of government to protect the people in the maintenance and exercise of their legal rights under private contracts.

But this legislation represents an unjustified attack on a massive scale by the Federal Government against the legal rights and contractual equities of literally millions of people. If rights and equities under millions of legal contracts of health insurance can be thus impaired by Government today, what other legal rights and values will be assaulted by unjust legislation in a different realm tomorrow?

Now, what changes will convert the bill into sound and constructive legislation? The time allowed for verbal testimony does not permit me to cover this in detail, so I have prepared a written supporting statement describing the amendments I recommend to your committee.

Briefly, I propose that the optional supplementary benefits package be deleted, and in its place a different kind of option provided.

The supplementary plan should be deleted because this optional provision, for which enrollees must pay a premium, serves no clear purpose which cannot be achieved by voluntary private insurance, and merely injects the Government into unfair, subsidized competition against private plans. The provision, moreover, is confusing, and those who are eligible will need to be educated to the fact that only part of the program is automatically provided under payroll-tax financing. Those who enroll will benefit from a subsidy which will be lost to others who, through ignorance, misunderstanding or unwillingness or inability to pay premiums, do not enroll. Any medicare plan which is really justified should be a unified, single plan under payroll-tax financing.

The kind of option that should be in the bill is one permitting any person coverd under a group or individual lifetime plan to continue his voluntary plan in lieu of coverage under the Federal benefits. He would still pay the tax, but upon electing to continue in a voluntary plan he would receive a Federal subsidy toward his premium payments after age 65, having a value equivalent to the value of the benefits under the Federal plan.

Such an option is actuarially sound if properly administered as described in my supporting statement. This would make the bill a constructive piece of legislation, helping those who need Federal assistance, while also encouraging the continued expansion of voluntary lifetime plans and at the same time protecting the people in their legal rights and equities under voluntary policies.

Let me digress briefly, Mr. Chairman, from the prepared text to strongly emphasize this fact. My proposed amendment will result in greater net benefit to the public at less eventual cost and without injustice to those now covered under voluntary lifetime plans. I have not consulted at all with insurance organizations or with representatives of the medical profession as to their views on this recommended amendment because I wanted to present independent, unprejudiced testimony expressing only my own professional opinion.

I assume that those now opposed to H.R. 6675 in its entirety will remain opposed even if this amendment is included.

However, I am certain they will remain opposed only temporarily. Eventually I think they will change their minds, and because of this amendment will eventually become favorable to this legislation. The amendment I suggest will do a better job for the public, and eventually also gain support, in my opinion, from doctors and from insuring organizations.

Thank you, Mr. Chairman, for your courtesy in hearing me.

(The attachment referred to follows:)

RECOMMENDED AMENDMENTS TO H.R. 6675

Delete the "Voluntary Supplementary Plan" provided in the bill and substitute the following optional program:

I. "Qualified" voluntary plans would be recognized under the law as follows:

Any individual policy which is guaranteed renewable for life, or any group certificate in force under a guaranteed continuable retirement provision of a group master policy, which provides benefits equal to or greater than the following minimum benefits:

(*a*) Benefits in the aggregate amount of at least $750 for any one injury or illness. Such minimum $750 may be allocated in any reasonable manner, provided that:

(1) Daily hospital room and board allowance must be at least $10;

(2) Daily hospital room and board must be covered at least 31 days;

(3) At least $100 of ancillary hospital services must be covered.

(*b*) If the plan has a deductible, the minimum $750 aggregate benefit of item (*a*) is increased by 8 times the amount of such deductible (e.g., with deductible of $50, the minimum aggregate benefit becomes $1,150).

(*c*) Covered expenses qualifying toward the minimum aggregate may include, in addition to hospital room and services coverage, any of the following: surgeons' and doctors' expense, nursing care, nursing home and convalescent home care, diagnostic expense, drugs and medicines.

(*d*) A qualified plan may not contain any "impairment exclusion" which excepts coverage with respect to specified impairments or histories of covered persons and which would apply after July 1, 1966.

II. (*a*) Any individual eligible for benefits under the law will be entitled to make an election at one time only to be covered under one or more qualified voluntary plans. If he later chooses to withdraw from the qualified program, he may reenter the Federal program but may not thereafter elect again to be covered under a voluntary program.

(*b*) When such an election of a voluntary plan is made, the individual will make such request through the voluntary carrier. Such carrier will notify the Social Security Administration, supplying (1) an affidavit that the plan is "qualified", and (2) information as to the amount of premium, which must be on a monthly payment basis.

III. (a) The Social Security Administration will render premium payments in behalf of eligible persons electing coverage under "qualified" plans.

The Administration will subsidize such payments up to $10 monthly per eligible person (the approximate value of the basic plan in H.R. 6675). Any excess of the premium over $10 per person will be deducted from monthly Social Security pension checks, or otherwise charged against whatever old age assistance or other program covers the individual.

(This method will assure that the plan does not lapse and will give equivalent Federal aid to both Federal plan and voluntary plan enrollees.)

(b) If the qualified plan is a group retirement plan of an employer, the employer will be entitled to monthly F.I.C.A. tax credits each month equal to the difference, if any, between $10 per person covered and such lesser amount as is charged to each covered retired person, but in no case shall the employer recover more than his actual share of the cost of the plan.

Example: A group retirement health expense plan is provided under a contribution rate of $4 per month per person. Total cost exceeds $10 per month.

The Social Security Administration pays the plan the full $4 per month per person contribution rate ($8 for man and wife) and in addition the employer is granted a further monthly credit against his F.I.C.A. tax of $6 per month per person ($12 for man and wife).

This proposed amendment is actuarially sound. It will minimize and stabilize the cost to the Federal Government, because in every case where persons elect voluntary plans the Government's share is specifically limited. Excess costs are borne by the voluntary carriers. Even if the remainder who elect the Federal plan should eventually prove to be only uninsurable persons who cannot obtain voluntary coverage, the Government's cost is still minimized, since the Federal plan would cover such persons in any case, with or without the proposed amendment.

The possibility of persons repeatedly electing to transfer back and forth between Federal and voluntary plans, in order to maximize their benefits under various circumstances, is eliminated by the strict rule as to number of elections.

The definition of "qualified" plan is flexible, thus allowing a wide area of competitive variation among carriers and permitting qualification of any reasonable plan of coverage. The law should avoid rigid definitions of qualification.

Senator McCARTHY. Thank you very much, Mr. Barnhart.

I am sure you know that the same points you have raised, namely equity and justice and the charge of confiscation, that all of these were raised by the private insurance people when social security was proposed.

Mr. BARNHART. I was not aware from what I had read in trade journals and the press that this particular point had been raised.

Senator McCARTHY. Essentially the same arguments were made against social security: that is was confiscatory; that is was denying the equity of people who had been saving money and investing in a retirement program; that it would discourage thrift on the part of people. None of those fears have been borne out in 30 years of history of social security.

Mr. BARNHART. You are referring to the original social security legislation.

Senator McCARTHY. That is right.

Mr. BARNHART. Well, I think this is very essentially different, because now we are talking about the reimbursements for charges for medical care and here you have a direct duplication, you see, of coverage which I do not think you have if you are merely providing cash pension benefits.

Senator McCARTHY. Well, you don't have any policy of not selling more than one medical or health insurance policy to the same client, do you? A man can be insured in three or four companies.

Mr. BARNHART. Most companies do not do this deliberately. For example, a person may become covered under group insurance and then he will buy an individual policy.

Senator MCCARTHY. If a man comes to your company, you don't say, "Have you got another health insurance policy with another company?" and if he says he has, you don't say, "We don't want you to be duplicating this."

Mr. BARNHART. Of course, I don't represent one company but most of the ones I have worked with will ask this question and then endeavor to underwrite——

Senator MCCARTHY. Will they suggest that they will not sell him two?

Mr. BARNHART. Many will say, "You are not eligible under our plan because you are covered in another."

Senator MCCARTHY. You are assuming that people are largely paying for these benefits, so it is not such a serious matter if they do receive more in return in the way of benefits under an insurance program than their actual costs, if they had paid for it.

Mr. BARNHART. Well, this has been a problem, I think, very specifically recognized by the National Association of Insurance Commissioners, that even though paying for duplicate coverage is definitely a social evil, because it permits certain people to profit from duplicate collection of benefits, and those who pay the costs, of course, are the premium paying policyholders.

Senator MCCARTHY. You assume, though—at least as you work it out on an actuarial basis—that each man you cover is making his contribution: that one man gets sick and the other man doesn't.

Mr. BARNHART. Well, in spite of this, I think it is almost universally agreed that nonduplication provisions are highly desirable and basically necessary in insurance legislation. Both on a group and individual basis, the National Association of Insurance Commissioners has now adopted antiduplication, you know, recommended antiduplication, legislation to prevent this overlapping of coverage.

I might say that my argument is not here intended to suggest that the Federal plan would discourage thrift. All I am trying to point out here is that there would be a discrimination between people who have chosen to invest in lifetime plans and those who have not, and the effects of the bill would be to impair or destroy their equity.

It isn't a matter of discouraging their thrift. It is a matter of actually injuring their equity.

Senator MCCARTHY. How does it destroy their equity?

Mr. BARNHART. Because since they will now, you see, become eligible for the Federal plan, they will be faced with the alternative of either abandoning the plan in which they have invested premiums or also continuing to carry it in duplication.

Senator MCCARTHY. They will be better off than they were before. It seems to me the argument you are making is this: If you have A and B, that you would prefer to have A be relatively better off than B, than to have both A and B be absolutely better off but to have the gap narrowed.

Mr. BARNHART. Well, I don't think both A and B would be absolutely better off, because in many cases A, the man who is now insured, would be abandoning his one plan.

Senator McCarthy. Why would he abandon it if what we are proposing it not as good as what he has got? This would be a mistake on his part, but it would not be our fault.

Mr. Barnhart. Because he may feel that because of the subsidy or the fact that the basic plan——

Senator McCarthy. Yes, he might "feel," but we can't take responsibility for that. It is not built into the law that we are proposing. Many people buy the wrong insurance.

Mr. Barnhart. It is not built in but I think it would be an inevitable result of the law, and I think that the committee should try to avoid this if at all possible.

Senator McCarthy. Thank you very much. Do you have any questions, Senator?

Senator Gore. No.

Senator McCarthy. The next witness is Mr. Coleman.

STATEMENT OF RALPH P. COLEMAN, JR., PRESIDENT, REVIEW PUBLISHING CO.

Mr. Coleman. My name is Ralph P. Colenian, Jr., of Jenkintown, Pa. I am president of Review Publishing Co., a publisher of financial periodicals, and of Review Management Corp., manager of an investment trust.

May I compliment the Senate Committee on Finance on its decision to hold public hearings on social security bill, H.R. 6675. Such a decision shows clear recognition of the historic implications of the bill and a deep respect for the democratic process which makes such hearings possible.

It is highly appropriate that it is the Committee on Finance that is conducting deliberations on H.R. 6675. For at heart the proposed social security amendments represent a radical reshaping of the personal finances of millions upon millions of U.S. citizens, both living and unborn, and of medical/health institutions throughout the Nation. As Senator Carl T. Curtis pointed out in floor debate in 1964 this program "will be permanent." The Senator succinctly commented: "Every time we add to the social security system, we set in motion something that will continue into the future."

I have carefully read and reread H.R. 6675, all 296 pages of it, and the thing that haunts me is the "open end" nature of the financial obligations to which the bill commits the Federal Government.

It is a cruel playing with words to describe title I—health insurance for the aged and medical assistance—as representing simple amendments to the present social security system. True, the social security structure would be used to collect the taxes for the proposed health insurance program. However, there are vast and vital differences between the present social security system and the proposed medicare program in that area which has equal fiscal significance with that of collecting the taxes for the program. That area is the "outgo" side of the ledger—the financial payments which must be made from the proposed Federal hospital insurance trust fund.

No less an authority than Representative Cecil R. King, cosponsor of the King-Anderson medicare bill, has freely admitted in his introduction of the bill on January 4, 1965, that "Social security hospital insurance would have no fixed dollar benefits that get out of date."

That definition may sound fine to the recipients of such benefits but for those of us concerned with the financing of such benefits it presents a situation fraught with the greatest of dangers.

Put another way, what Representative King is saying is that his hospital insurance proposals make payments on the basis of services rendered rather than on the basis of fixed cash payments. That makes medicare vastly different in kind, rather than degree, from Old-Age, Survivors and Disability Insurance with its precisely developed schedules of fixed dollar payments to recipients.

The sustained and unremitting advance in hospital costs in recent years was clearly substantiated by medicare's senatorial sponsor, Senator Clinton P. Anderson, who noted on January 6, 1965, in introducing bill S. 1 before the Senate:

"Since 1946, the average cost for one day of hospital care has risen from $9 to nearly $40."

By the Senator's own figures, that represents an increase of 344 percent in less than 20 years.

Now, consider carefully the deadly combination of factors which makes the cost components of the proposed medicare's hospital care programs so utterly incalculable.

On the one hand, we have proposed a program that recognizes no dollar limit on its expenditures and that pays only for services rendered. Now let's look at the services rendered. They are hospital and medical services that are, according to such experts as Senator Anderson and the Advisory Council on Social Security, among the most rampantly inflationary segments of the entire consumer price structure in the United States. And there seems to be ample evidence that this inflationary price trend in medical costs will continue into the foreseeable future.

I submit, gentlemen, that this represents a situation laden with the seeds of financial disaster—the Federal Government convenanting with its citizens to provide them with benefits of a highly personal and necessary nature and being uncertain in the extreme as to what those benefits will cost. It is simply beyond the ken of even Federal experts to know just how many people will utilize the services of the proposed hospital insurance program; and how many days of service and types of services which these people will require.

A greater demand for hospital/medical services, which would certainly be unleashed by H.R. 6675 becoming law, is bound to sharply increase the costs of all medical and hospital services, when one considers the relatively static supply of such services. As prices for hospital services continue to rise one must recognize the possibility of pressures from both the Federal Government and the beneficiaries of medicare for governmental price control over medical services and supplies.

In his statement issued on January 5, 1965, entitled "Hospital Insurance for the Aged—The Conservative Approach," Hon. Wilbur J. Cohen, U.S. Under Secretary of Health, Education and Welfare, commented:

> The Social Security financing system is based on the idea that the individual will contribute part of the cost of his protection. It thus stresses contributory participation against the "free" or general revenue or welfare approach embodied in the Kerr-Mills program.

Yet in H.R. 6675, the very bill that Mr. Cohen's Department endorses, we have an unparalleled example of the "free" or general revenue approach which is completely contradictory to the basic principles of social security. I refer to that section of H.R. 6675 which would provide benefits for about 2 million aged persons not covered by the present social security insurance program and whose benefits would be financed entirely by appropriations from general tax revenues.

Section 103 is completely candid and generous in admitting to hospital insurance benefits anyone not eligible for social security benefits. The requirements, as I understand them, are rather simple. He must be 65 years of age; he must be a resident of the United States and a citizen; or he must be an individual who has resided in the United States continuously during the past 10 years. My reasoning from the latter provision would be that aliens who have been in the country for 10 years or more would be eligible for the same hospital insurance benefits as U.S. citizens. Surely no alien should be entitled to health insurance benefits if he has not at least formally petitioned for U.S. citizenship.

Section 1801 of title XVIII—Health Insurance for the Aged—is entitled "Prohibition Against Any Federal Interference." The section reads:

> 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.

Even a cursory reading of H.R. 6675 will reveal the total hypocrisy of this section. Without attempting to catalog the scores of specific instances, the following examples are offered in support of my strong belief that H.R. 6675 will result in truly sweeping Federal Government advances into the very vitals of the American medical profession and the related institutions which serve the health needs of our Nation.

Section 1802 gives a strong portent of things to come:

> Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or persons qualified to participate under this title.

And who does the "qualifying" of such institution, agency, or person? Primarily, the Secretary of the Department of Health, Education, and Welfare, aided by various "accrediting groups," such as the Joint Commission on the Accreditation of Hospitals. It is rather illuminating to learn that fewer than half of U.S. hospitals are accredited and that, of the 20,000 nursing homes in the United States, only 500 are hospital affiliated.

What a vast arena for the Federal Government to discriminate between those institutions which it feels are "qualified" and those which are not "qualified".

What of the potential power of the Health Insurance Benefits Advisory Council, all 16 members of whom would be appointed by the Secretary of HEW, who would receive up to $100 per day, who would meet "as frequently as the Secretary deems necessary," and whose purpose would be "advising the Secretary on matters of general policy

in the administration of this title (Health Insurance for the Aged) and in the formulation of Regulations under this title."

What of the potential power of the National Medical Review Committee, all nine members of whom would be appointed by the Secretary of HEW, who would receive up to $100 per day, and whose purpose would be "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 seem desirable."

Are we naive enough to believe that any of the individuals serving on these two powerful bodies could be any person who disagreed with the Secretary of HEW? With the Secretary of HEW doing all of the appointing that would appear to be a very unlikely development.

Certainly, some provision should be made so that representatives from such recognized professional groups as the American Medical Association and the American Hospital Association would be automatically entitled to serve on the Advisory Council and the Review Committee, such representatives to be elected or appointed by the associations rather than to be appointed by the Secretary of HEW.

The crucial, central role of the Secretary of HEW in the future medical/hospital life of the Nation under H.R. 6675 is made crystal clear in many sections of the bill such as section 1815:

> The Secretary shall periodically determine the amount which would be paid under this part to each provider of services (hospital, extended care facility, home health agency) with respect to the services furnished by it, and the provider of services shall be paid, at such time as the Secretary believes appropriate.

In regard to the recipients of health insurance benefits the Secretary is in an equally commanding position as evidenced by section 1869:

> The determination of whether an individual is entitled to benefits under part A or part B shall be made by the Secretary in accordance with regulations prescribed by him.

Surely, if this doesn't make of the Secretary of HEW a medical czar it at least makes of him a medical crown prince.

The coercive character which is integral to the successful operation of a bill so broad and so deep as H.R. 6675 is most dramatically delineated in the relationship of the Secretary of HEW to the various States concerning "Grants to States for medical assistance programs."

The authoritarian "comply or else" position of the HEW Secretary in regard to the development of such programs is shown in section 1903(3):

> 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.

Here is a plain case where the HEW Secretary "cracks the whip" and the States "jump" or lose the Federal payments which would be a key part of their medical assistance programs.

I believe there is something extremely monopolistic and possibly illegal about section 1842(b)(1) which concerns the use of carriers, such as Blue Cross, for the administration of benefits under the proposed Supplementary Health Insurance Program for the Aged (part B). This section reads:

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.

I understand by this section that the Secretary of HEW can simply decide to give to a carrier of his choosing large administration contracts without going through the competitive bidding process which has been devised over the years as the fairest way known for the Federal Government to deal with private groups bidding for public business. I believe such an exemption is contrary to governmental concepts which prohibit monopoly and foster free competition, as exemplified by the antitrust laws.

Finally, I must deplore the fact the passage of H.R. 6675 would represent another giant step toward centralization of more and more of our national life in Washington. Hospital and medical care is a very personal type of relationship. As such, regional and local patterns of living must be observed if such care is to be most effective. Ways of doing things and of grouping people in hospitals and nursing homes that might be completely satisfactory in one part of the country, with its particular set of customs and mores, might cause difficult social relationships if applied in other sections of the Nation where the customs and mores are different. But H.R. 6675 makes no provision for varying local and regional traditions—it will, in effect, "nationalize" all hospital care—at least for the aged—to one concept and one standard developed in Washington.

In view of the antagonisms and strife that have been fermenting in our Nation for many years in the area of human relations I think sober consideration should be given to any Federal proposals that would accelerate rather than inhibit such fermentation.

Thank you for your kindness in listening to my comments on H.R. 6675.

Senator GORE (presiding). Thank you, Mr. Coleman.

This concludes the public hearings on the bill.

The committee will commence executive consideration of the bill on Tuesday, May 25.

We stand adjourned.

(By direction of the chairman, the following is made a part of the record:)

STATEMENT OF NATIONAL PHARMACEUTICAL COUNCIL, INC., NEW YORK, N.Y.

(Submitted by Newell Stewart)

Mr. Chairman and members of the committee, The National Pharmaceutical Council, Inc., is an organization composed of 25 companies engaged principally in the manufacture of prescription drugs. It was created to assure the public of high-quality pharmaceuticals by promoting optimum professional standards at the manufacturing, distributing, and dispensing levels. The council adheres to the principle that the physician's prerogative to perscribe a precise drug for his patient be held inviolate, and one of its aims is to assure proper methods and procedures so that a patient will receive the specific drug or brand of drug that is ordered by his physician.

The council respectfully urges that (1) the definition of the term "drugs" and the term "biologicals" as presently set forth in section 1806(j) of S. 1 be changed and (2) the provisions concerning the determination of cost of services in section 1809(b) be amended for the reasons and in the manner set forth below.

It is the firm belief of the National Pharmaceutical Council that legislation should not interfere in any way with the practice of medicine or the manner in

which medical services are provided. Section 1801 of S. 1 recognizes this principle by stating:

"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 to exercise any supervision or control over the administration or operation of any such hospital, facility, or agency."

The National Pharmaceutical Council further believes that a corollary of this principle is that a physician's determination of the drug to be administered to his patient should be made on the basis of what he believes to be the best, specific medication for his patient and not by the predetermined availability of a limited number of drugs listed in a compendium of drugs or selected by a committee of other physicians, nor should the physician's determination of the drug to be administered be influenced by the amount of reimbursement to be made to the provider of services.

For these reasons the council urges that section 1806(j) be changed to read as follows:

"(j) The term 'drugs' and the term 'biologicals', except for purposes of subsection (g)(5) of this section, include such drugs and biologicals as are ordered or prescribed by the attending physician on the medical staff of a hospital having an agreement in effect under section 1810." and that section 1809(b) be amended by adding the following words immediately following the first sentence of this section which ends with the word "agencies"; "Except as provided in subsection (c)(1) of this section, costs for items or services furnished a patient shall be deemed to be reasonable if they are ordered or prescribed by the patient's physician for medical reasons, and if such costs do not exceed the amount customarily charged by the provider of services to persons not subject to this title."

FEDERATION OF CITIZENS ASSOCIATIONS OF THE DISTRICT OF COLUMBIA

(Submitted by John R. Immer, President)

The health committee of the Federation of Citizens Associations on February 23, 1965, voted unanimously in expressing opposition to medicare for the aged under Social Security because its members—only one of them a physician—believe that under this sort of regime medical care would be extremely costly and would unnecessarily increase payroll deductions far beyond current rates.

It believes that under State and locally administered programs, with Federal help, those actually in need would be better served and the quality of medical service would be better. It therefore adopted the following resolution:

"*Be It Resolved* That the Federation of Citizens Associations of the District of Columbia does support and approve the bill H.R. 8727 introduced by Congressmen Herlong and Curtis and known as the eldercare bill, for the following reasons:

"1. No elderly person needing health care shall be denied because of inability to pay.

"2. It is appropriate that Government revenues be used to finance health care when other resources have been found to be inadequate.

"3. Every level of government—municipal, county, State, and Federal—should assume a responsible share in financing such programs.

"4. The health care provided by the programs should be adequate and should be equal in quality to that available to those who can pay.

"5. Maximum use should be made of voluntary prepayment and insurance mechanisms.

"6. Administration of such a program should be the responsibility of State governments. Participating States should be required to meet adequate standards of administration in order to qualify for Federal funds.

"7. Eligibility requirements for benefits should be fair, realistic, uncomplicated, and practical.

"8. Any such health care program should provide funds only and not direct services.

"9. Funds for such programs should come from general tax revenues and not from Social Security."

Approved by the federation February 25, 1965.

Dr. EDWARD A. KANE,
HANSON T. PERKINS, M.D.,
Cochairmen, Health Committee.
Mrs. EDWARD B. MORRIS, *Secretary.*

TEXAS ACADEMY OF GENERAL PRACTICE, TARRANT COUNTY CHAPTER, FORT WORTH, TEX., IN OPPOSITION TO COMPULSORY SOCIAL INSURANCE MEDICINE

Whereas in June 1961 the American Medical Association House of Delegates passed the Bauer statement which reads as follows:

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay; and it further believes that the profession will render that care according to the system it believes is in the public interest; and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare."

Whereas it has become apparent that compulsory social insurance medicine will be a part of whatever omnibus health care or social security bill is offered this Congress; and

Whereas the built-in controls in any such system would make hospitals, patients, and physicians subordinate to the Secretary of Health, Education, and Welfare; Therefore be it

Resolved That each of the members of the Tarrant County Academy of General Practice is urged to refuse to be a party to any such regimentation; and be it further

Resolved That the membership is also urged to call this resolution to the attention of colleagues, hospital administrations, and the public.

Passed in regular meeting March 17, 1965.

ASSOCIATION OF MINNESOTA INTERNISTS RESOLUTION AND LETTER

MINNEAPOLIS, MINN., *March 24, 1965.*

Senator WALTER F. MONDALE,
U.S. Senate, Washington, D.C.

DEAR SENATOR MONDALE: Thank you very much for your thoughtful reply to my letter some time back in reference to the proposal on national health legislation by the Association of Minnesota Internists. You may be interested to know that the House of Delegates of the American Society of Internal Medicine (the society is comprised of 8,000 physicians) wholeheartedly approved our resolution even though it was accused by one member of being socialistic (I am sure you are aware it is not a program for socialized medicine even though it does contain a comprehensive proposal for health care for catastrophic illness for the entire population). We now face the difficult task of getting our proposal accepted by the American Medical Association which, as you know, is committed to the support of the so-called eldercare bill. We do feel our proposals, frankly, are superior to either or both the Herlong-Curtis and the King-Anderson bill, and although it is obviously true we are extremely late with our proposal, we still feel that we would be amiss if we did not try. We will be extremely grateful to you if you will ask your colleagues in the Senate what they think of our proposals, and let us know their suggestions. We feel we are in an unusual position to help influence medical opinion, but before we embark on an intensive program of so doing, we want to be sure that our proposals are workable.

Sincerely,

C. E. LINDEMANN, M.D.,
Chairman, Medical Liaison Committee,
Association of Minnesota Internists.

RESOLUTION 1, ASSOCIATION OF MINNESOTA INTERNISTS TO BE PRESENTED AT THE 1965 ASIM NATIONAL CONVENTION

Whereas legislation is presently pending in the Congress of this Nation which will, if passed into law, drastically affect the practice of medicine; and

Whereas the overwhelming preponderance of practicising physicians in this country have indicated their dissatisfaction with some principles embodied in the aforesaid legislation; and

Whereas the Association of Minnesota Internists embarked on a program of evaluation of national health legislation approximately 9 months ago, for the purpose of proposing action on the part of ASIM during 1965: Therefore, be it

Resolved, That the American Society of Internal Medicine proceed, with the utmost diligence, to formulate its own policy as to national health legislation, with such policy to embody all parts of the following recommendations which, after additional careful study on a national level, are proven to be workable in solving the Nation's health problems.

RECOMMENDATIONS

1. National health legislation policies can be soundly formulated only through careful correlative studies, involving, at the very least, representatives of the Government, the insurance industry, and the medical profession. Because of this, it is deemed advisable that—

(*a*) Representatives of ASIM seek liaison with interested individuals in other fields related to the problems concerned in the further development of all important concepts.

(*b*) The American Medical Association encourages the study and formulation of ideas on the matter among members of the profession. Because of this, the American Society of Internal Medicine has the unparalleled opportunity of using its unique concentration on socioeconomic matters toward solving the biggest problem of the medical profession during the 20th century. Once formulated, the findings and conclusions of ASIM should be submitted to the governing bodies of the AMA in a timely manner, in order that organized medicine can utilize what is meritorious therein in presenting its case to Congress and the American people.

(*c*) It is specifically recommended that Members of Congress be enjoined to hold a national conference on health legislation, with representatives from all involved groups present, prior to the passage of any pending legislation on health insurance, in order that such can embody the experiences of each.

2. Whereas the target of most national health legislation proposals has been those Americans over an arbitrarily selected age, the real problem created by the advances in medical science consists in the overwhelming costs of protracted, severe illness wherever it may strike. In order for a solution to this problem to be truly effective, it cannot direct its efforts toward a part of the problem; it must seek to protect all Americans when catastrophe strikes. As a consequence, ASIM should depart from the existing pattern, and seek a national policy of medical insurance for all who fall victim to overwhelming medical expense.

3. In a like sense, there is no wisdom in affording protection in situations where need is nonexistent. Doing so would be open invitation to overusage. There is no evidence that, in the United States, there is a need for Federal legislation to provide for medical expense coverage for either short-term medical care, or for the ordinary routine care of the common chronic illnesses. The indigent are covered by existing Federal and State laws, and, if any such need exists, it can most efficaciously be taken care of by extending them. New health legislation should be directed toward major medical expense alone, and ASIM should pursue such a direction.

4. At the present time, private health insurance is available which protects its beneficiaries from medical expenses beyond a minimal deduction and up to maximums of $10,000 to $15,000. Such coverage would appear to characterize the real needs of the American people generally.

While it is not within the province of a group of physicians alone to set the deductible amount which the overwhelming preponderance of Americans could sustain in a short time, such a figure would appear to be between $300 and $500. Coverage of the above type, for a family of two adults and two children, covering an illness for a period up to 3 years, would cost the average wage earner about 1½ percent of his monthly income.

Since the goal of this program is to include all people, some of whom may not be eligible under existing coverage through private insurers, the Government must assume some fiscal responsibility for collection and distribution of premiums.

5. The relationships between the degree of governmental regulatory control of medical facilities and medical costs has a long record of direct proportionality. Because costs of government at all levels are approaching their limits of tolerance, and because medical expenses on a national basis could severely aggravate such a condition, it would appear to be sound policy to limit the role of the Federal Government to that minimal one commensurate with success of the plan. In our opinion, this role would include the following:

(*a*) In order to get all people into the program, it appears necessary that subscription be compulsory. The Government is best equipped to accomplish this through the use of the income tax agencies. Along with tax payments, payments can be made for health insurance. The simplest method of allowing individuals to procure their own insurance thereafter would appear to be the return to the taxpayer (or income tax return filer) of a certificate from the Internal Revenue Bureau, which he could use to procure his choice of private major medical insurance. As will be seen later, such a choice can be of considerable importance in a plan covering citizens of all ages.

(*b*) A special fund, perhaps labeled as the "tax insurance fund," would be set up nationally as a depository for health insurance payments made to the Government, with premiums paid from such funds to insurance carriers as health plan certificates are turned in by them. This fund would be under governmental control. It seems possible that, during an initial adjustment period, moneys from the general fund would be needed as supplements to the tax insurance fund, until experience ratings determined the true costs involved. After an experience period, the tax increment paid by individuals would equal the value of certificates, plus an additional amount needed to cover insurance company losses in providing such coverage.

(*c*) In turn, private insurance companies participating in the program would establish a reinsurance pool amongst themselves. This pool would be administered, collectively, by them, and the companies, individually and collectively, would report to and share in the experience of the reinsurance pool on all coverage provided under the proposal.

If benefit payments plus expenses of the private insurers, as reflected in the operation of the reinsurance pool, exceed the premiums collected, the Government would subsidize the reinsurance pool from moneys held in the tax insurance fund (or taken from the general fund). As experience under the program emerges over a period of years, the individual contribution level would be adjusted to reflect the actual benefit costs plus administrative expenses incurred in providing the coverage.

6. In order to prevent overutilization of medical service after payment of the initial deductible amount, it would appear wise to include a coinsurance feature in all coverage. Such a feature would entail payment by the insured of a small part of additional costs. How such payments should be applied might best await the development of this concept by insurance experts. As an example, however, the individual might be expected to pay 20 percent of the cost of the first thousand dollars; 10 percent of the cost of the next thousand, etc.

7. Coordination between the compulsory major medical program and other aspects of private health insurance as presently established is a factor of considerable significance in the formulation of such a program.

(*a*) Private industrial corporations have already established extensive group health insurance plans for their employees. Where such plans exist, major medical premiums under the above plan can be used to supplement them: either by extending such coverages or otherwise.

(*b*) By combining compulsory major medical with other types of coverage, private carriers could continue to maintain a competitive relationship with each other, to the public's benefit.

8. From the standpoint of what medical services would be included in the coverage of major medical insurance, a number of factors are of importance. These include the following:

(*a*) It would appear reasonable to cover charges by qualified physicians, both in the hospital and out of it. This is true because—

(1) While most office charges would be unlikely to exceed the deductible amount, followup care after discharge from a hospital would be in excess of the deduction.

(2) Under currently existing private health care plans, there is an undeniable waste, due to the fact that hospitalization occurs so that patients may be covered by their insurance. Were coverage for office charges to be a part of such plans, the public would be saved the cost.

(3) There is a real possibility that, if Government-sponsored and other insurance plans were to cover the hospital but not the office, private practitioners would be forced to forfeit income to hospitals, and patient care would degenerate through substitution of the hospital-employed doctor for the private physician.

(*b*) Hospital and nursing home care, which comprise the greatest expense among modern medical costs, would necessarily be covered under the plan.

(*c*) Home nursing care, properly supervised and developed, can readily serve as a means of precluding hospitalization. They should be included and encouraged as part of the health care plan.

(*d*) The costs of drugs and appliances prescribed by physicians outside of the hospital should probably be included in the plan, though such might well need more careful study and regulation than other aspects of care.

9. Utilization review boards, on a hospital staff basis, are becoming a significant factor in the practice of medicine, and are a healthy development when kept within the profession, whether connected with Government-sponsored health

insurance or not. They should be developed within the profession, and cannot logically include lay people, who cannot judge the merit of medical procedures, and, therefore, could only add confusion to the functioning of such groups.

10. In strict contrast, provisions in pending legislation in Congress provide for granting certain powers of discretion as to utilization to the Secretary of HEW and, through him, to State health agencies. They also provide for the creation of a Hospital Insurance Advisory Council to assist the Secretary. It would appear that such powers and appointments are both inadvisable and unnecessary under our proposed plan for the following reasons:

(*a*) The primary purpose of national health legislation at this time is to alleviate financial disasters to people created through medical expenses. There is no indication that existing regulations, within the profession and outside of it, are not adequate for the policing of the care doctors are giving their patients.

(*b*) If overutilization is a matter for consideration, a serious look at its presence or absence in Government-sponsored institutions should serve as a guide to the capabilities of Government agencies in this regard.

(*c*) The presence of a deductible amount and of a coinsurance clause in Government-sponsored health coverage, such as is recommended in our proposal, is far more effective in curbing overutilization than are Government boards and councils devoted to this matter.

11. Summary: The prime target of national health legislation should be determined initially before such legislation is passed into law. It is our contention that this target must be the amelioration of financial disasters, following in the wake of catastrophic illness, and that previously recommended concepts have been aiming wide of the mark. Our recommendations have been made with the thought of covering the need, the whole need, and nothing but the need. It is our opinion that, if such a policy is adhered to, in any consideration as to health legislation, the public welfare will be maximally benefited and minimally harmed.

GEO. A. HORMEL & CO.,
Austin, Minn., April 8, 1965.

Re H.R. 6675 (medicare).

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: This bill, as reported out of the House Ways and Means Committee, contains a provision which we regard as unwise. We bring the matter to your attention since, after passage by the House, the bill will doubtless be considered by your committee.

As you know, the present social security law provides for the payment of benefits to coverd individuals who have been disabled for a period of 6 months and who are determined to be permanently disabled. H.R. 6675 would make these payments available without any determination of permanent disability.

Our company, through union negotiation, has made provisions to pay disabled employees 70 percent of base pay for up to a full year. Other companies have similar provisions. In fact, in the packing industry generally benefits of this nature are payable for a period of time equal to 2 weeks for each year of service.

After the first 6 months of disability, if an employee is able to receive not only 70 percent of his base pay but also disability pay under the social security system, he has almost no incentive to return to work. In our view this is a most undesirable result. It could be avoided completely by the maintenance of the present requirement of a determination of permanent disability before the employee becomes entitled to disability benefits under the social security law.

We urge your careful consideration of this particular proposal to change the social security law. We think it is a far-reaching change, the full implications of which are easily overlooked.

Yours very truly,

I. J. HOLTON, *Secretary.*

THE PAGE MILK CO.,
Merrill, Wis., April 10, 1965.

Senator HARRY F. BYRD,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: It has come to our attention that a provision was inserted in H.R. 6675 in the House Ways and Means Committee without public discussion, and probably without too much information being released in regard to it. I have reference to the liberalized definition of "total disability".

As I understand this matter, the new H.R. 6675 provides that disability payments may be made to an insured worker who has been disabled for at least 6 calendar months, even though there is every reason to believe that he will recover in the reasonably near future. I believe the provision also is such that the disability payments would be made to him even though the disability arose out of employment and he was being paid workmen's compensation.

Aside entirely from all other aspects of H.R. 6675, I would urgently request that you and your committee take action to remove this measure liberalizing this total disability but, at the very least, I would urge that disability benefits not be applicable where the worker receives workmen's compensation benefits.

I would further raise the question about the provision in this bill as to who determines the disability and how and when determination can be made at the end of disability.

In summary, this provision in the bill provides an undesirable liberalization of permanent disability, distorting it entirely out of reality. The provision opens the door to a very dangerous dual-benefit situation, which can result in greater incentive to the employee to malinger and, at the same time, it can result in serious weakening of State workmen's compensation law as we know it today.

Again, I would urge that you and your committee remove this provision from the bill while it is before you.

Yours very truly,

GEO. B. PAGE.

ASSOCIATED BABY SERVICES, INC.,
New York, N.Y., April 12, 1965.

Re: Section 303, H.R. 6675

Hon. HARRY F. BYRD,
Senate Office Building, Washington, D.C.

SIR: The above section relative to disability benefits should be eliminated unless workmen's compensation benefits are offset against disability benefits under the social security program.

The amendment would create two "monsters," one of idleness and one of unnecesarily increased payroll tax and insurance costs to be borne by the employer.

The loss of incentive to return to work on part of the disabled person which would surely result from receipt of benefits in excess of his normal net pay would be a great loss to the community.

Very truly yours,

RICHARD H. KRAKAUR, *Controller.*

DOVER, OHIO, *April 11, 1965.*

Senator HARRY FLOOD BYRD,
Washington, D.C.

DEAR SENATOR: As the long-standing watchman over our purse I wish to make a few comments to you regarding the current health bill.

First of all I see no need for governmental aid even to people over 65 unless they are in need. As treasurer of a local nonprofit hospital of about 150 beds I know that already about 70 percent of people over 65 have provision made for their health needs through Blue Cross, insurance, or workmen's compensation. And at least until the cost is indicated by a trial on those who need help, I feel we should go slow lest we undertake something that will cost too much.

Secondly, as treasurer of a hospital I am concerned with the solvency of hospitals under the current plan. Unless payment to hospitals covers depreciation, obsolescence and something for bad bedts as well as direct costs, the hospitals will be in trouble. Depreciation—as hospitals must be constantly rebuilt. Obsolescence—because with the rapid changes in medical technology equipment must be dropped and new purchased to properly serve the public. And part of the bad debts—for with individuals having to meet the first $40 of $50 of the bill, hospitals will stand a loss on much of that amount. A substantial part of hospital loss is from inability to collect the small balance due from Blue Cross patients, and the difference between the patient's insurance and billed charges.

Also consider how the bill would affect people carrying Blue Cross to cover his family when the patient is over 65, but wife and children younger.

Very truly,

THOMAS L. KANE,
Treasurer Union Hospital Board.

CAMBRIDGE, MASS., *April 13, 1965.*

Senator HARRY FLOOD BYRD,
Chairman, Senate Committee on Finance, Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I am writing to you with regard to H.R. 6675 which passed the House of Representatives a few days ago. The following comments are on H.R. 6675 as introduced by Mr. Mills. I am assuming that the bill passed by the House is essentially the same as that which was introduced by Mr. Mills. I would like to comment on two titles: (1) amendments proposed as new title XIX entitled Grants to States for Medical Assistance, pages 124–146; and (2) title II of H.R. 6675, Other Amendments Related to Health Care.

NEW TITLE XIX: GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS, PAGES 124–146

In general may I say that I am glad H.R. 6675 does extend medical assistance to children and families that come under "aid to families with dependent children"—title IV of the Social Security Act—as well as the aged, the blind, and the disabled. Since returning to my native State of Massachusetts, I have had an opportunity as chairman of the Massachusetts Committee on Children and Youth to learn a good deal about what happens to children under the Social Security Act programs. We are making some pilot studies in two areas of the health supervision and medical care that are received by children and it is our intention in the not-too-far-distant future to make more extensive studies in this field. I am, however, convinced that much can be done to improve the scope and quality of the health supervision and medical care provided for these who are some of our most deprived children.

One of the major problems, as I review the situation here and elsewhere in the country, is that programs in most States do not provide for a well-worked-out organized program and plan of providing health supervision and medical care for these families. Until such an organized program is developed in each State to which the mothers of these families can turn for advice and help whether their children are well or sick, it is not to be expected that good preventive care, as well as good treatment, will be made available.

I am writing to you now to urge you to make appropriate amendments to proposed title XIX of the Social Security Act—Grants to States for Medical Assistance programs—that will assure that responsibility for the administration of medical assistance programs to persons receiving public assistance under the Social Security Act will be placed in the State department of public health. This will, I believe, require amendments to section 1902 of the proposed title XIX (pages 125–129) of H.R. 6675.

Specifically, I am not satisfied that the provision of section 1902(a)(5) is the best method of administration of a medical-care program for people receiving public assistance under the Social Security Act. I would recommend that a new subsection be substituted that will "provide that the State Department of public health shall administer or supervise the administration of the State plan for medical assistance." This would mean that each State health department would administer this program and (as provided in section 1902(a)(9)) would "provide for the establishment or designation of a State authority 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."

If the State departments of public health are established as the State agencies to administer the State plans for medical assistance, provision should be made in the bill requiring the State departments of public welfare (or other State departments that now administer titles I, IV, X, XIV, or XVI) to certify to the State department of public health for medical care all persons receiving public assistance or general relief under these programs. I believe that all other eligible individuals (not on public assistance) who are unable to pay the costs of medical care should be in a position to apply directly to the State department of public health for their medical care.

I am not satisfied that the provision under section 1902(a)(4) at the bottom of page 125 and the top of page 126 for "utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan" would be a sufficient safeguard for the provision of high-quality medical care to the recipients of public assistance. If this

program of medical assistance is to be of high quality, its direction and supervision should be in the hands of medical authorities from the top administrators down to the localities where care is given. It is for this reason I think that the State departments of public health should be given the full administrative responsibility for these programs.

Since the public assistance titles of the Social Security Act are under the administrative authority of the Secretary of Health, Education, and Welfare, it would seem to me quite possible that he could work out appropriate responsibilities for the Public Health Service, the Children's Bureau, and the Bureau of Family Services for the administration of this medical assistance title of the act. The Children's Bureau has the know-how with respect to mothers and children and the experience in administering from the Federal level programs of medical care; the Public Health Service has much information and knowledge with regard to the medical needs of the aged; the Bureau of Family Services has the past experience of providing the financing for medical care of the aged through the MAA program and the other public assistance titles. Clearly the Public Health Service and the Children's Bureau together could prepare appropriate programs and methods of administering this proposed new medical assistance program.

TITLE II: OTHER AMENDMENTS RELATING TO HEALTH CARE

Part 1: Maternal and child health and crippled children's services (pp. 146–151)

Section 201 and section 202.—I am in entire accord with the provision to increase the authorization for appropriations for maternal and child health services and crippled children's services. I am also in accord with the proposal that these services be extended within each State with a view to making them available by July 1, 1975, to children in all parts of the State.

I am assuming that this latter provision for the statewide extension of the services will call for a clear definition of what these services should be. It seems clear to me that the Secretary under his power to make rules and regulation should outline the standards for "maternal and child health services" and "crippled children's services" giving their scope, extent, character, and quality of service expected.

I note that in sections 201(a) and 202(a) the language originally proposed to make the authorization for the appropriation for these two services open ended has been deleted and a ceiling of $60 million for the fiscal year ending June 30, 1970, and succeeding fiscal years substituted. I do not believe that such a fixed amount is compatible with the provision for extending the services to children in all parts of the state by July 1, 1975. If the latter provision is to be implemented, and I hope it will be, then the authorization for appropriations will have to be open ended.

Section 203.—Training of professional personnel for the care of crippled children. I am in entire accord with this proposal.

Section 204.—Specific project grants for health of school and preschool children (pp. 149–152).

On page 151, lines 6 to 13, there is a condition that says, "* * * 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 as may be provided for in regulations of the Secretary." I do not understand why this condition is limited to children and youth of school age and omits preschool children. I would like to suggest that an insert be added to page 151 that says, "and preschool children."

Part 2: Implementation on mental retardation planning

I'm happy that H.R. 6675 provides for the extension of section 1701 of the Social Security Act authorizing planning to combat mental retardation.

With kindest regards, I am,

Yours sincerely,

MARTHA M. ELIOT, M.D.

CAMBRIDGE, MASS., *May 13, 1965.*

Senator HARRY F. BYRD,
Chairman, Senate Committee on Finance,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: Thank you for your letter of April 15, 1965, in response to mine of April 13 in which I made comments on H.R. 6675 and proposed certain admendments.

I am writing now to suggest another amendment that I regard as very important.

I would strongly recommend amending H.R. 6675, section 205, which provides for special projects grants for health of school and preschool children by inserting on page 150, either in line 13 after the comma or in line 15 after the comma, the following phrase: "and to any school of public health."

I believe it is urgent that our schools of public health as well as our medical schools be eligible to receive funds under these projects so that the maternal and child health divisions or departments in such schools may provide administrative leadership of high quality to such projects under the new section 532 of the Social Security Act.

With others here in Massachusetts, including the State department of public health, the Massachusetts Committee on Children and Youth, of which I am chairman, is examining the question of how one or more projects under this new program may be established so that comprehensive health protection and medical care of truly high quality may be made available to the children eligible for care under the proposed program. I believe that schools of public health should be named in the bill as well as medical schools as I have suggested above.

With kind regards, I am,

Yours sincerely,

MARTHA M. ELIOT, M.D.

SOUTHERN CALIFORNIA CANCER CENTER,
Los Angeles, Calif., April 14, 1965.

THE HON. HARRY F. BYRD,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: The Southern California Cancer Center is a nonprofit organization approved by the U.S. Government and local governments. It is very much interested in the new medicare bill which is now being proposed, H.R. 6675.

As a nonprofit organization, one of many in this country approved by the Federal Government, it seems logical that these organizations should be included if we are to have a medicare program. These nonprofit organizations give treatment for many conditions and do not necessarily put the patient to the expense that is encompassed by going to a hospital unless hospitalizeation is necessary.

I am writing you to ask you if you believe it would be feasible to include nonprofit organizations in this new bill.

This letter is written at the suggestion of our local Representative, the Honorable Edward R. Roybal.

Sincerely yours,

HUGH F. HARE, M.D.

Victoria, Tex., April 11, 1965.

Senator HARRY BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The Six Flags Pharmaceutical Association representing all registered pharmacists of Victoria, Calhoun, Goliad, De Witt and Lavaca Counties has passed a resolution which states our opposition to the House-passed H.R. 6675 in its present form.

Objection No. 1 lies in the fact that all persons 65 years or over would be covered for hospital, nursing care, drugs and doctor fees, etc., even though many of these could well afford to pay their own way. This places a burden on the taxpayer which should not be there.

Objection No. 2 lies in the fact that the cost of a 7-percent-across-the-board increase in social scurity, plus increases that will more than double in the years to come will also spiral the burden on the taxpayer and employers.

These increases in the social security payroll tax on the individual must also be met by the employer, thus making him raise his prices to offset this increase in overhead. This only adds to the already existing inflation of our economy.

We do therefore urge that you use your influence, position, and vote to alter or defeat H.R. 6675 in its present form and find a more economical plan of caring for our elderly who actually need help.

Sincerely yours,

WILLIAM O. MOORE, R. PH., *Secretary-Treasurer.*
Six Flags Pharmaceutical Association.

ST. LOUIS 8, MISSOURI, *April 14, 1965.*

Senator HARRY BYRD,
Senate Building, Washington, D.C.

DEAR SENATOR BYRD: The Missouri State Medical Association just completed its 107th Annual Convention and passed with slight modification and without opposition the enclosed resolution. The accompanying statement with minor changes was made in support of the resolution and when presented in subcommittee met with enthusiastic endorsement. This attitude represents a great change in thinking among physicians as a whole and portends a more cooperative and constructive attitude in the future.

The representation of physicians in the AMA has tended to represent the hard core conservative element, which has dominated local medical politics, rather than the mass of physicians who, as in all groups, lie mostly in the middle between left and right.

We do believe, however, that medicare is a bad bill since it covers the entire society over a certain age without concern for need. The experience of the British has been so costly, it has been suggested that a means test be introduced to prevent bankruptcy of their plan. The administration of such a national plan will be horribly expensive and establish a new empire in Washington. It is the greatest step toward a socialized society yet to be made and assuredly will be only the first.

Enclosed is a clipping[1] from the AMA news on a survey of public opinion by the Opinion Research Corp., Princeton, N.J. What a shame to plunge forward into the beginning of a fantastic change in our society that has never been demonstrated to be the will of the people. Being a Democrat and wanting medicare are by no means synonymous.

The Curtis-Herlong bill is a much gentler entry into a new field. With all the spending that is now being approved and the present crush of taxes which has contributed to our national disease of anxiety, I urge you to oppose the medicare bill.

I am writing to you rather than my own Congressmen because I think you are more openminded and the only person with sufficient stature to resist Presidential pressure.

Thought you might also be interested in the enclosure from Roch Labs, which arrived today.

Yours very truly,

EDWARD D. KINSELLA, M.D.

PROPOSED RESOLUTION

Whereas over the years the American Medical Association has frequently been blamed and criticized for a national image of reactionary opposition to federally sponsored public health plans; and

Whereas the AMA is frequently accused of failure to represent the opinion of the majority of physicians: Now, therefore, be it

Resolved, That we of the MSMA publicly endorse the basic precepts enunciated by the AMA in its opposition to these plans, currently and specifically medicare, and reaffirm our support of the American Medical Association; be it further

Resolved, That regardless of the outcome of pending health care legislation, the AMA be encouraged to exhibit a progressive imaginative leadership in the study and furthering of attractive alternatives to a socialized system of medicine

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[1] Not inserted in the record.

which will otherwise follow in the evolutionary sequence of events; and be it further

Resolved, That notification of this action be forwarded to the AMA and all State Medical Societies.

Reasons for this motion are:

1. To exhibit unity of opinion and support of AMA opposition to measures which sanction or promote socialized medicine.

2. To express a large body of medical opinion which favors a leadership interested not only in opposition but one leading the way in constructive alternative proposals that will block the evolution of socialized plans.

3. To see the AMA become identified with progress not counter reaction.

4. To imply the belief that an attitude of persistent opposition eventuates in a greater loss of desired ends than does active participation in planning to mold the future.

5. By taking positive action, to prevent a massive spirit of defeatism that will split physicians into two groups and weaken medical doctor opposition to socialized medicine.

6. The AMA has come out with eldercare only because they have been forced into a last ditch, defensive position and not as a result of forward looking leadership. It is this approach to planning that should be changed. Eldercare, however, does represent constructive, national, health care planning by the AMA and for this the AMA is to be praised. There must be continued planning on a national level.

It is not possible to maintain the status quo in our changing society and physicians must become identified with energetic leadership. Physicians are by nature a laissez faire, conservative group which has succeeeded around the world in losing its stature in the morass of socialized medicine. We are as vehemently opposed to this as any among you with strong feelings but do believe the way to avoid socialized medicine is to endorse a leadership with imagination for alternative changes in keeping with the demands of our restless society.

Old-age legislation is only the first step. The next has already been introduced, namely, to cover the young. And who is to say that the needy in between the young and the old should not also be covered by a national health plan? Are physicians going to sit back and wait to be told what to do or again hope for a last minute alternative, or will they plan a better plan to block the call for an extension of socialized medicine.

8. You have seen yourselves evolve from the position of refusing to accept Government money for your services to the point where the AMA through eldercare now proposes precisely such a plan. Here we are introducing payment of doctors' fees on a Federal level. You criticize medicare as "hospicare" because it left out doctor care. Apparently, many Washington legislators were shocked and so were many physicians. The views of the rigid right have become strangely quiet and one senses already some spirit of defeatism.

9. The reactionary attitude that has typified our body and the AMA is engulfed in the natural consequence of its own rigidity. When a reactionary opposition is beaten, it is through, and its voice becomes weak. But, if we help plan for the future and can inculcate a new enthusiasm for imaginative leadership in the AMA then the prospects for our future and a continuation of the best medical care of our patients willl be ever so much brighter.

It is not too late except for defeatists and for those who would hold the line.

10. This is the philosophy of progress that should be carried into the presidency of the AMA.

EDWARD D. KINSELLA, M.D.,
St. Louis.

SUBMITTED BY MRS. JOSEPH WILLEN, PRESIDENT, NATIONAL COUNCIL OF JEWISH WOMEN, INC., NEW YORK, N.Y.

The National Council of Jewish Women urges early favorable action by the Senate Finance Committee on H.R. 6675, the Social Security Amendments of 1965. We believe, with President Johnson, that this bill is indeed a "landmark" in social legislation, providing for the first time in our country's history medical care for the elderly and disabled under social security.

The position of the National Council of Jewish Women was reconfirmed at our national biennial convention last month "to work for a social security pro-

gram which will provide social insurance as the basic method for financing the costs of medical care for the aged and disabled."

This current statement of our view, adopted by elected delegates representing our 320 affiliated local units across the country, has developed naturally from our history of support of the principles of social security dating back to 1935 and from our work with the elderly.

For the past decade we have been working with older people through some 200 varied service projects across the Nation. We know from them and from a survey of medical costs among members of council golden age recreation centers, that fear of illness and anxiety about meeting large medical bills is widespread and constant. Since only a small percentage of Americans are able to save enough during their working lives to sustain the cost of protracted or catastrophic illness in old age, medical care financed through social security is the program most likely to meet health needs and remove a primary cause of poverty among the growing group of elderly in our population.

The National Council of Jewish Women considers medical care financed through social security the best way to meet these acknowledged needs. We still believe, as we stated in May 1962, that "Far from being an infringement of freedom, it enables the individual to preserve his dignity * * *. Unlike plans through which the Government appropriated public funds to pay for medical care for people who can't afford it, a social insurance plan keeps the Government out of the medical field by enabling each individual to provide for himself."

THE MARY FLETCHER HOSPITAL,
Burlington, Vt., April 16, 1965.

HON. WINSTON L. PROUTY,
Senate Office Building,
Washington, D.C.

DEAR WIN: Hospital board members and administrators have requested me to express to you our united and vigorous opposition to the exclusion of the professional services of radiologists, pathologists and anesthesiologists from the definition of hospital services as contained in H.R. 6675 "Social Security Amendments of 1965." This provision means that these professional services must be billed for separately from the hospital bill.

In Vermont, the hospital is the base for all X-ray diagnosis and treatment performed by radiologists. The hospital is the base for practically all laboratory tests done on patients. The patient expects these X-ray, laboratory, and anesthesia services to be part of the hospital services and, in practically every case, one bill covers the services of both doctor and hospital.

Exclusion of the services of the pathologists from the hospital bill, for example, would completely upset the relationship worked out over a long period of time between the Vermont College of Medicine and its primary teaching hospital in respect to pathology and laboratory service by the 12 pathologists on the college faculty. These pathologists have voluntarily limited their personal income under a three-way agreement in order to aid the teaching and research program of the college.

Patient care is bound to suffer if this inequity is not corrected. In the teaching hospitals, where many residents are trained, the anesthesiologists have agreements with the hospitals and their income is not dependent upon whether a patient is rich or poor. Thus a ward, or service patient receives the level of skilled anesthesia indicated by the seriousness of his condition, whether he can pay or not. We do not like to think that the excellence of anesthesia could be pegged to the size of the patient's pocketbook.

In Vermont 43 percent of the people are covered by Blue Cross which covers practically all X-ray and laboratory costs. If the radiologists' and pathologists' compensation is excluded from the hospital bill, the entire Blue Cross-Blue Shield arrangement will be shattered after 25 years of long service to the public. This will create a chaotic condition which people will just not understand.

Exclusion of payment for the services of hospital-based specialists from the hospital bill is bound to increase the cost to those people not under provisions of H.R. 6675. Many under this act undoubtedly cannot or will not pay the doctors fees as billed by the specialists. That means increase in charges to others to offset the losses. The paperwork involved in separate billing for laboratory and X-ray would be enormous and increase the cost of doing

business at a time when we are all concerned about the continuing rise of hospital and medical care.

There are certain facts that we must face. The radiologist, the pathologist, and the anesthesiologist have a captive practice because the hospital is there and the patients are admitted by other physicians. The patient has no choice of radiologist, pathologist, or, generally, the anesthesiologist, nor can he bargain on charges for the reason that these specialties are monopolistic. Under existing practices, the hospital governing body exerts a certain measure of control over charges and is definitely concerned about quality of practice. The governing board has the legal obligation to protect the patient's welfare. We should not lose these checks and balances that have worked so well for so many years.

The seemingly inocuous section which excludes the services of hospital-based specialists from the definition of hospital services would revamp our entire system as it would not, perhaps could not, be limited to medicare alone. Is that what is really intended?

Win, I hope you will do all in your power to protect the medical-hospital relationships that have been so successful and effect the revision proposed by Senator Douglas. I am enclosing a reprint of his remarks and the telegram from Dr. Crosby as contained in the Congressional Record—Senate, page 6830, April 6, 1965. As member of the board of trustees of the American Hospital Association, I am pleased that Dr. Crosby has expressed the position of hospitals so well.

I am sending a similar letter to Senator Aiken.

If either you or Senator Aiken feel that you need more information or if we can be more persuasive by a personal visit, we would be pleased to have a small delegation of hospital trustees and administrators meet with you in Washington at your convenience.

Thanks for all your consideration.

Sincerely yours,

Les,
LESTER E. RICHWAGEN,
Executive Vice President and Administrator.

THE ISSUES

The issues involved in the exclusion of the medical specialties (radiology, pathology, anethesiology, physiatry) from H.R. 6675 are clearly apparent to hospital administrators and boards of trustees throughout the country.

1. The American Hospital Association has a long history in support of the position that the services of radiologists, pathologists, anesthesiologists, and physiatrists are integral parts of hospital care. In 1957 the board of trustees of the association gave recognition to this fact when they officially endorsed the inclusion of these services in Blue Cross contracts as hospital services.

2. The provision of these services is inherent in the years of efforts to improve the quality of patient care in hospitals. Even though the individual physicians involved were accorded full professional stature in every sense of the word, the administration and provisions of these specialty services developed within the sphere of hospital services. The removal of such services is a backward step and one which may jeopardize continued efforts to improve the quality of patient care in hospitals.

3. 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. We have continually urged that the Federal Government not interfere in the relationships which are worked out locally between the hospital and the physician-specialists. The language in the bill passed by the House does interfere in such relationships and could force a nationwide renegotiation of all contracts between physician-specialists and hospitals. In addition, widespread renegotiation between hospitals and Blue Cross plans and between Blue Cross plans and the million of their subscribers would be necessary.

4. It is unlikely that the aged beneficiaries will understand the significance of the deletion of these physician-specialists' services until they are in hospitals.

Then they will be informed that these physician services are no longer included in the costs to be borne by the Federal Government, and they will receive multiple billings from the physician-specialists. We believe this constitutes a large reduction in anticipated benefits and will constitute a major change in practices to which the public has become accustomed.

5. Administrative difficulties inherent in this change will be formidable. The administrative problems within hospitals will be greatly increased; administrative difficulties in connection with the administration of the overall program as well as that of the physician-specialists themselves will be greatly increased.

6. It is believed that the removal of the specialists' services will tend to increase the overall cost of care to aged people.

7. It is believed that the removal of these services will undermine the quality of care in small hospitals where the volume is such that it is not possible to arrange continuous full-time specialist services. The quality of care in such hospitals has been markedly improved by arrangements with physician-specialists visiting on "circuit rider" arrangements. The economic problems involved in obtaining such physician services in the future, if hospitals were forced to withdraw their guarantees to such specialists, would seriously curtail such services. Specialists would have to make individual billings and collections with considerable uncertainty as to any assured income for his services.

8. Overall it is believed that if this division in specialist services remains for aged beneficiaries under this legislation it will certainly lead to an extenson of the practice to all other patients and the necessity of renegotiating nearly all existing arrangements for the remuneration of physician-specialists in hospitals.

[From the Congressional Record, Apr. 6, 1965]

AMERICAN HOSPITAL ASSOCIATION STRONGLY URGES REINSTATEMENT OF SERVICES OF MEDICAL SPECIALISTS AS REIMBURSABLE COSTS UNDER AGED HEALTH CARE BASIC PLAN

Mr. DOUGLAS. Mr. President, on March 29 I urged, in a Senate speech, that the Senate restore to the House committee approved plan for expanded medical and hospital care for the aged reimbursement under the basic plan of the in-hospital services of medical specialists. While I dislike the barbaric English usage of some of the titles, the official designations of these specialties are radiology, pathology, anesthesiology, and physiatry.

After making this speech, I sent a telegram to Dr. Edwin N. Crosby, executive vice president of the American Hospital Association, asking the position of the association on this matter. The telegraphed reply of Dr. Crosby on behalf of the association speaks for itself, but I point out in summary his evaluation that the exclusion of these services: First, would seriously retard the continued development of the modern hospital as the central intsitution in our health service system; second, not only will confuse the public through a multiple-billing approach and cost them more, but could endanger the quality of patient service; third, interferes with existing relationships between hospitals and physicians and tends to dictate a nationwide pattern prescribed by the Federal Government; fourth, is certain to face aged beneficiaries with a substantial reduction in the benefits they will receive; fifth, will imperil the longstanding arrangements developed by many Blue Cross plans; sixth, will make the administration of the overall program enormously more complicated; and seventh, will require nationwide renegotiation of contracts between hospitals and specialists and between hospitals and third party agencies.

I earnestly hope the Senate will act to correct this exclusion, and I ask unanimous consent that the text of Dr. Crosby's telegram be printed in the Record.

There being no objection, the telegram was ordered to be printed in the Record, as follows:

APRIL 5, 1965.

Senator PAUL DOUGLAS,
U.S. Senate,
Washington, D.C.:

In reply to your wire the American Hospital Association takes the position that radiology, pathology, anesthesiology, and physiatry services in hospitals are essential to the provision of high quality patient care in the hospital and thus are basic hospital services. Exclusion of these services would seriously retard

the continued development, so striking in the past few decades, of the modern hospital as the central institution in our health service system. The association's historic policy position that radiology, pathology, anesthesiology, and physiatry are hospital services was clearly enunciated on February 7, 1957, by our board of trustees when it acted to include these benefits as benefits of prepaid hospitalization benefit plans.

Fragmentation of the components of hospital service not only will confuse the public through a multiple billing approach and cost them more, but more importantly could endanger the quality of patient service in the hospital by diminishing the administrative controls necessary for the optimum delivery of these services cordination of which is so essential to high quality hospital care. The association maintains the position that these services including the professional activity of the specialist are a proper part of hospital reimbursable costs.

In testimony before the House Ways and Means Committee in its hearing on similar legislation in July 1961 we urge that these medical specialists' services be included in the hospital benefits proposed and we argued strongly against the delegation of such specialists' services from the bill. More recently we expressed our support of the provision of such services as it was incorporated in H.R. 1. We opposed interference by the Congress in the local arrangements developed through the Nation by the individual specialists and the hospitals concerned. We were distressed that the services of these specialists were removed from the definition of hospital services in H.R. 6675. We believe that this interferes with existing relationships between hospitals and physicians and tends to dictate a nationwide pattern prescribed by the Federal Government. The present provisions of H.R. 6675 in respect to these specialists will, we believe, seriously disturb the existing relationship throughout the Nation and may as above noted threaten in certain instances continued efforts to improve the quality of patient care. It is certain to face aged beneficiaries with substantial reduction in the benefits they will receive under the legislation. The longstanding arrangements developed by many Blue Cross plans will be imperiled. The administration of the overall program will become enormously more complicated. The required total separation of the particular physician's services involved from the departmental costs of hospitals will require nationwide renegotiation of contracts between hospitals and specialists and between hospitals and third-party agencies. The effects will most likely be extended overall to hospital patients.

We strongly urge the reinstatement of the services of these specialists as a part of hospital services in the legislation you finally pass.

EDWIN L. CROSBY, M.D.,
Executive Vice President,
American Hospital Association.

OGDEN, UTAH, *April 14, 1965.*

Hon. Senator FRANK E. MOSS,
Senate Office Building,
Washington, D.C.

DEAR SENATOR MOSS: It seems so inadequate but please accept by heartfelt thanks for your kindness in providing me with a copy of H.R. 6675 of the 89th Congress.

Time has not allowed of my reading it all in studied detail but I am familiar with the main provisions.

In a bill so sweeping and complex, proposing as it does, a vast and significant change in the manner of providing medical care for more than 20 percent of our citizenry, there are necessarily some provisions with which most anyone might disagree. Of this I am deeply aware, and also conscious of there being much emotional as well as rational argument engendered concerning some provisions, occasioned by the bias we each possess.

Nevertheless, I am aware that H.R. 6675 represents a distillation from many sources. I think it is definitely a superior bill to S. 1.

If an amending sentence can be added, I would suggest including provision that outpatient diagnostic services be included when performed by a duly authorized and licensed commercial medical diagnostic laboratory, not just hospital laboratories. Most of our diagnostic work is now performed by such laboratories.

When the Congress has passed this legislation and it becomes law, I am sure we physicians will learn to live with and practice satisfactorily under it.

For the elderly, I feel certain that we shall be able to provide a quality of care which many cannot and do not now receive, however vociferously the opposite is stated.

With sincerest good wishes and personal regards.

Sincerely,

J. G. OLSON, M.D.

VERMONT HOSPITAL ASSOCIATION,
Springfield, Vt., April 17, 1966.

Hon. GEORGE D. AIKEN,
U.S. Senate, Washington, D.C.

DEAR SENATOR AIKEN: The House of Representatives has passed H.R. 6675 concerned with health care of the aged, and this vital legislation is soon to receive the consideration of the Senate. Vermont hospital trustees, hospital management people, the people of Vermont at large, and many of those devoted to medical professions have noted with alarm that the House Ways and Means Committee has removed all physician services from the first part of this important bill. We are therefore expressing to you and Senator Winston Prouty our views on exclusion of physician services.

Members of the Vermont Hospital Association and other Vermonters interested in health care of the aged have been calling me to express their deep concern over the sudden change in this legislation. In providing for basic hospital services and skilled nursing home care for persons 65 and over, the original intent of the bill was to assist our retired elderly citizens in their battle to meet rising costs of living, especially today's high cost of providing hospital and medical care. Hospital charges for radiology service, pathology service, and other professional departments of the hospital were to be covered for the senior citizen. Under the new provisions stated in H.R. 6675, the elderly patient will not be covered for the physician fee portion of these charges, but must be responsible for additional billing from medical specialists whose services would not be covered as hospital services.

The exclusion of services of the medical specialists will require multiple billing of patients and will duplicate administrative mechanisms of accounting, billing, and collecting. The new expense of paying for existing hospital administrative costs and new medical-specialist administrative costs will be borne by our Vermont patients. This increases the overall cost of care to aged people.

Hospital departments, such as radiology, pathology, and physical therapy have reached maximum efficiency under this Nation's voluntary, nonprofit hospital system. Lay trustees who receive no compensation have been able to oversee patient care in the public interest, and every possible efficiency under this type of hospital organization has helped us keep medical service costs realistic. Exclusion of services of medical specialists from the hospital departments which now offer both specialist and hospital service, will take from the public all voluntary trustee influence on pricing of these services. It could shatter the fine voluntary partnership of physician specialists, hospital trustees, and the public which has taken decades to build.

The membership of the Vermont Hospital Association, composed of hospital trustees, administrators, accountants, and hospital service department heads, sincerely asks that you investigate the many factors which make us look with disfavor on removal of all physician services from the basic hospital services provided in H.R. 6675.

Sincerely yours,

THOMAS F. HENNESSEY, *President.*

GRAND FORKS DEACONESS HOSPITAL,
Grand Forks, N. Dak., April 5, 1965.

Hon. MILTON R. YOUNG,
U.S. Senate, Washington, D.C.

DEAR SENATOR YOUNG: It seems assured that a form of the King-Anderson bill will be passed some time in the near future. I have some strong reservations about its underlying philosophy but that doesn't seem to matter too much now since the social security approach to caring for the aged seems to have been accepted by the majority of Congress. I think there are a few items in the bill that must be stressed.

First of all, I think it is absolutely essential that Blue Cross be accepted as the administrative intermediary. They are so close to hospital problems and are still independent that a reasonable job can be done in this area. To place any other agency in this area would lead to all sorts of problems because it would take them a long time to understand hospitals and their problems. This would certainly lead to undue delay and hardship on everyone's part.

Next, in setting standards, I feel very strongly that those set by the Joint Commission on Accreditation of Hospitals should be recognized and followed. To have any other agency set up standards would be gross interference in hospital affairs. In addition, we would have two accrediting agencies to be concerned with, which would certainly not work.

Another point to be concerned with relates to billings for pathology and radiology services. It is a common practice throughout this country to have a pathologist and radiologist paid on a percentage basis. They operate as a part of the hospital team in this manner. I understand the bill, as it now stands, would separate the pathologist and radiologist fees and would not pay for them. This would be inappropriate. These doctors are responsible for directly supervising their respective departments as well as individuals providing direct or indirect service to their patient. I certainly believe they should be considered as part of the hospital bill submitted to the patient.

Finally, the development of a cost reimbursement formula will be very important. One of the obvious results of the development of this formula will be to additional emphasis on the idea that hospital charges should be placed on those services where costs are incurred. At the present time, most hospitals are undercharging for room, board, and nursing care and overcharging for such services as laboratory, X-ray, dressings, treatments, etc. This system has been in vogue for many years. Hospitals have been attacking this system for the last few years and some headway is being made. I am certain that the Government will insist that we make new charges, which will be good. Then we must expect to see room rates increase at a very rapid rate. Along with this, I believe the Government should have a formula which will pay us for full costs of services rendered—not reasonable costs. If the hospital can justify these costs, they should be paid for them. If they cannot, then that is their own problem and they should not be paid on that basis.

We must do all we can to maintain the doctor-patient relationship and to insist on maintaining the integrity of the hospital. It is obvious that some controls will have to be made. It is also obvious that these controls will increase as the years go by. It is hoped that as the bill is set up, certain steps will be taken to maintain the good parts of the medical care program to our people. If this can be done, all is not lost.

Sincerely,

ROBERT M. JACOBSON, *Administrator.*

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY,
DEPARTMENT OF SOCIAL WELFARE,
Sacramento, March 31, 1965.

Hon. GEORGE MURPHY,
Senate Office Building, Washington, D.C.

DEAR SENATOR MURPHY: I am enclosing a brief statement to support a suggested amendment to H.R. 6675, now in the House Ways and Means Committee, to make possible payments to "interested" or "concerned" persons in behalf of an aid recipient when the best interests of the recipient require this.

In urging you to muster the strongest possible support for this suggestion, I am speaking not only in my own behalf as State director, but also in behalf, and at the request of, many of the county directors and other persons vitally concerned with the sound administration of the public assistance programs created by Federal law.

Thank you for the help I am sure you will give us.

Very sincerely yours,

J. M. WEDEMEYER, *Director.*

STATEMENT REGARDING PAYMENT TO PERSON OTHER THAN RECIPIENT IN AID TO BLIND AND AID TO DISABLED PROGRAMS

One of the major problems in all public assistance programs which provide money to needy persons is this: Generally, it is most desirable to pay cash and

to enable the recipient to manage his own money and his own life. But there are situations in which this would be contrary to the best interests of the recipient.

If the recipient is so handicapped that guardianship or conservatorship can be obtained, there is no problem.

But if the individual is not so incompetent or handicapped that a guardian or conservator is legally required, there are many cases in which the direct cash payment may actually be contrary to his best interests because of the probability of mismanagement. Whether this takes the form of foolish purchases, drinking, improvident loans or failure in some other way to use the grant in order to obtain the necessities of life is not important. What is important is that there be some other way to assist in meeting the true needs of the recipient in these exceptional kinds of circumstances.

The principle has already been adapted and tested as sound in title IV of the Social Security Act. It is now embodied in the Ways and Means proposals in H.R. 6675 as far as the aged are concerned. There seems to be no valid reason why all titles should not be covered.

The need for a solution is recognized in H.R. 6675, now under consideration of Ways and Means Committee of the House of Representatives. Sections 402 (a) and (b) would amend, respectively, sections 6(a) and 1605(a) of the Social Security Act to provide for payment to a person "interested in or concerned with the welfare of the needy individual" under certain, carefully circumscribed conditions.

Section 1605 is part of chapter XVI which covers all three adult programs, but this State does not presently claim under that title but rather under titles I, X, and XIV. As long as a State claims under these titles, it is precluded from using title XVI.

It should be urgently suggested that H.R. 6675 be amended to include provisions parallel to present sections 402 (a) and (b) to cover the aid to the blind and aid to the permanently and totally disabled programs established by titles X and XIV, respectively.

Present section 402 of the bill already points the way, since it recognizes the need to make possible this exception to the cash payment principle in all three of the programs for adults.

Attached in draft form is language which would accomplish this if incorporated in H.R. 6675. These will have to be fitted into the bill with the resulting changes in the numbering of other sections.

PROPOSED AMENDMENT TO H.R. 6675 TO PROVIDE FOR PROTECTIVE PAYMENTS TO THE NEEDY BLIND

SEC. 402. 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 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 1002 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 assistance 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 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;

"(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 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 repre-

sentative, as described in section 1111, if and when it appears that such action will best serve the interests of such needly individual; and

"(e) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (a) for any individual with respect to whom it is made."

ASSOCIATED INDUSTRIES OF MASSACHUSETTS,
Boston, April 21, 1965.

Hon. HARRY F. BYRD,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: As chairman of the Workmen's Compensation Committee of the Associated Industries of Massachusetts, I would like both individually and in a representative capacity to express deep concern over the elimination of the requirement of indefinite duration from the definition of compensable disability as proposed under section 303 of the Social Security Amendments of 1965.

Very briefly, we see two significant problems. First, the proposed changes will constitute an unpredictable pyramiding of Federal and State benefits by entitling a worker with 6 months total disability to social security benefits as well as any benefits otherwise available under State Workmen's Compensation Acts. Serious areas of duplication of benefits already exist in the cases of widows' benefits and workers who are under permanent and total disabilities. This is particularly true with reference to a number of States including Massachusetts where, for example, a liberal benefit structure permits an injured worker with a wife and two dependents to collect 76 percent of his prior weekly earnings in nontaxable benefits. Moreover, evidence of concern over the issue of duplication of benefits is implicit in the recommendation of the House Ways and Means Committee that the Social Security Administration undertake an investigation of the overlapping benefit problem and report its findings by December 31, 1966. This attitude of uncertainty, alone, should be sufficient reason for rejection of section 303.

Second, the apparent reason for the inclusion of section 303 would seem to be an attempt to diminish the effectiveness of State workmen's compensation laws while at the same time magnifying the role of social security in the field of industrial injuries. If the basic motivation underlying section 303 is indeed further Federal encroachment into areas normally comprehended under State laws, it is a matter of such importance that it deserves separate public review and discussion. It cannot and should not be considered part and parcel of a general social welfare program the impact of which is on a greatly differing field of concern.

For the foregoing reasons we respectfully urge the Senate Finance Committee to delete section 303.

Respectfully,

A. LIONEL LAWRENCE,
Chairman, A.I.M. Workmen's Compensation Committee.

NATIONAL BISCUIT CO.
New York, N.Y., April 20, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee, Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I should like to call your attention to section 303 of H.R. 6675, a bill to amend the Social Security Act.

Section 303 as amended would remove the present definition of disability or impairment and substitute therefor the word "impairment". It would further provide that the only requirement to qualify for disability benefits is that a person be disabled or suffer an impairment for a successive duration of 6 months. If this liberal requirement is met, a covered worker may, upon proper application, receive social security disability benefits beginning with the sixth month.

This proposal would change the concept from a permanent and total disability benefit, and in fact would make the disability provision of the law into a liberal sickness and accident benefit with no test of disability except that it has endured for a period of 6 months.

Under the proposed language of section 303, an employee who sustains a work incurred injury and who is being compensated in accordance with a State workmen's compensation or other similar law would become eligible for dis-

ability payments concurrent with payments for the same disability under such other law, provided only that he is disabled continuously for 6 months.

I should like to suggest that the Senate Finance Committee give earnest consideration to deletion of section 303 amendments from H.R. 6675. Or, in the absence of complete elimination of this amended section 303, at least further amend it so an injured worker who is receiving benefits under a workmen's compensation or similar law cannot automatically qualify for a concurrent social security disability payment for the same cause. In our opinion, no person should receive benefits under two social insurance programs for the same disability.

This does not mean that we agree with all other provisions of bill H.R. 6675. If, however, the time has come when we must have such legislation, there should be adequate deterrents to malingering and overuse to properly safeguard public funds.

Respectfully yours,

J. H. BURGESS, JR.
Vice President, Personnel Relations.

AMERICAN ELECTRIC POWER SERVICE CORP.
New York, N.Y., April 21, 1965.

Re: H.R. 6675, Disability Benefits.

Hon. HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Section 303 of H.R. 6675, the "Social Security Amendments of 1965" bill now pending before the Committee on Finance, contains provisions which, in my opinion, are not justified and which in the long run could quite adversely affect the present State-Federal disability benefits program and its costs to employers and employees.

At the present time, disabled individuals may receive benefits under both State workmen's compensation laws and the Social Security Act. "Disability" for this purpose, however, is now defined in the Social Security Act as impairment "which can be expected to result in death or to be of long-continued and indefinite duration" (secs. 216(i)(1)(A) and 223(c)(2)). Section 303 of H.R. 6675 would amend these sections to strike out the quoted language and authorize dual benefits for temporarily disabled employees. Disability benefits under the Social Security Act would commence after a 6-month waiting period, without offset for benefits paid under State laws.

A temporarily disabled employee receiving both State and Federal disability benefits might receive more than his take-home pay if he worked. In some States the disability benefits now provided, plus the disability benefits which would be allowable under H.R. 6675, would exceed the average take-home pay. There is a definite trend to increase the benefits under State laws. The net economic benefit of dual disability benefits as compared with wages is heightened by the fact that wages are subject to Federal and perhaps to State income tax, whereas both State and Federal disability benefits are not. Thus the proposed amendment of the Social Security Act would have the effect of making it more profitable to maintain the temporary disability status than to return to work or receive rehabilitation treatment.

Enactment of section 303 would also operate to diminish the present financial incentive of employers to continue and improve the safety programs which have been vigorously carried on the last 30 years, with substantial reductions in the accident rates. The employer's cost under State programs depends upon the accident experience of his employees. This is not so under the Social Security Act; the tax on employers, and on employees, is the same regardless of the accident experience. Extension of the Federal benefits to temporary disability would at best reduce the financial incentive to maintain and improve present safety standards and precautions, and would practically remove it if the enactment of section 303 caused States to repeal their workmen's compensation laws so that disability benefits would turn into a wholly Federal program.

In sum, to extend the Federal benefits to temporary disability is not in the interest of the rehabilitation, and the return to useful employment, of injured employees who are not permanently disabled, or the continuation and improvement of present accident-prevention measures.

Very truly yours,

A. W. D. GRONNINGSATER.

SPICE ISLANDS COMPANY,
South San Francisco, Calif., April 20, 1965.

Hon. HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: As a member and chairman of the Senate Finance Committee, you are deliberating on a bill, H.R. 6675, amending the social security laws to provide medical care. Included in this legislation is a very liberal definition of total disability insurance benefits which could be paid under social security.

Under the present law, disability insurance benefits (to which I am opposed on a Federal level), are payable under social security only if a worker's disability is expected to result in death or to be of long and indefinite duration. Under the proposed change in H.R. 6675, disability benefits would be paid an insured worker who has been totally disabled for at least 6 calendar months even though it is expected that he will recover in the foreseeable future. The social security benefits would be paid whether or not the disabled worker was receiving workmen's compensation benefits. In other words, dual benefits would be paid. In 47 States, it is estimated that the joint Federal and State payments would exceed the take-home pay of the average worker and thus discourage rehabilitation. Making a larger number of people eligible for social security payments without reducing those payments by the amount received under State workmen's compensation is a further attempt to weaken State systems.

The bill leaves open the question of who will determine the disability and how and who will determine when the disability ends. I urge your strong efforts in the Senate Finance Committee to eliminate the disability amendment.

Sincerely,

R. D. PARRISH, *Controller.*

UNITED STATES FIDELITY AND GUARANTY CO.,
St. Louis, Mo., April 20, 1965.

Re Congress H.R. 6675, Social Security Amendments of 1965

Senator HARRY F. BYRD,
Chairman, U.S. Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: In the first place, it is my opinion that the above captioned bill was railroaded through the House in a very undemocratic fashion. Althought the bill was under consideration by the House Ways and Means Committee for several weeks, there were no indications that disability benefits would be extended until a few days before the bill was reported. Vote in the House took place under closed rule, without opportunity for amendment.

Under the bill, workmen's compensation would be duplicated by social security in all cases of temporary and permanent total disability lasting 6 months or more. Duplicate payments, however, would begin with the end of the fifth month. Presently, social security disability benefits are payable for only permanent total disability.

It seems doubtful that two compulsory statutory systems providing benefits for the same disability will both be permitted to continue for long. The danger to workmen's compensation is obvious, since combined benefits, especially at the increased benefit rate provided in the bill, would exceed average take-home pay in at least 47 States. This would obviously lead to malingering on the part of workmen's compensation claimants, and would naturally increase the cost of social security and workmen's compensation, ultimately, again resulting in the necessity for higher taxes.

The report of the House Ways and Means Committee discusses the offset question but orders a study by the Social Security Administration. It would seem only logical to await the results of such a study before taking action so prejudicial to workmen's compensation. The situation is similar to that which occurred when the offset provision was repealed in 1958. At that time, a one line repealer of the offset was unexpectedly included in a 108 page bill that was certain to be enacted by the Congress. That measure became law within 4 weeks after introduction.

To preserve workmen's compensation, the broadened definition of disability under the bill must be eliminated, or an offset provision enacted. I earnestly urge your cooperation.

Yours very truly,

JOHN W. HOFFMAN, *Manager.*

NATIONAL ICE & COLD STORAGE CO.,
San Francisco, Calif., April 19, 1965.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I have been informed that H.R. 6675 contains a provision on disability which can be interpreted as a weakening of State workmen's compensation laws.

Unless my information is unreliable, passage of this bill in its present form would allow both social security benefits for disability and State workmen's compensation benefits to be paid to a disabled worker which would result in payments which would exceed the take-home pay of the average worker and thus discourage rehabilitation.

I believe this would be a most unwise course of action and sincerely ask that you support the elimination of the proposal to liberalize the disability provision of social security law in H.R. 6675.

Sincerely yours,

FRANK DEGEN,
Executive Vice President.

SECURITY MUTUAL CASUALTY CO.,
Chicago, Ill., April 23, 1965.

Medicare bill H.R. 6675,
Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

MY DEAR SENATOR BYRD: The recent passage by the House of the medicare bill, including section 303, was, in my opinion, a rather unfortunate situation. I feel that section 303 alone will at least double social security's duplication of workmen's compensation insurance programs, which, in my opinion, will seriously hamper the efforts of many insurance companies to rehabilitate insured workers and get them back either to their former position or to employment of some kind. This provision alone, I believe, calls for request of our Representatives in Washington to vote against the passage of this bill.

In addition to the impact of this legislation upon the workmen's compensation efforts of many insurance companies, passage of this bill would result in higher taxes imposed upon employees and employers alike. I therefore urge you to vote against the medicare bill in its present form.

Yours very truly,

C. M. ELSNER.

GULF STATES TELEPHONE CO.,
Tyler, Tex., April 23, 1965.

Hon. HARRY FLOOD BYRD,
Chairman, U.S. Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: We, as an employer in the State of Texas for over 50 years, are writing you in deep concern over section 303 of the social security "medicare" bill (H.R. 6675) which is now in the hands of the Senate Finance Committee.

In reviewing the contents of this bill, section 303 is extremely objectionable and should be eliminated from the bill. This section 303 proposes to extend social security benefits now provided for totally and permanently disabled workmen to those whose disability is only temporary beyond a period of 6 months. This extension will embrace thousands of additional workmen who are being compensated under various workmen's compensation laws. As you may know, unsuccessful attempts have been made to require that social security disability benefits be offset in the amount being received as workmen's compensation. As a result many injured workmen now receive cash benefits (from social security and workmen's compensation) in excess of their wages prior to injury. Now it is proposed by this section 303 that social security benefits be extended to a still larger group who suffer less serious industrial injuries and, again, with no

provision to reduce such disability payments by amounts being received as workmen's compensation payments.

We feel that: (1) This is a further encroachment by the Federal Government into a social concern (compensation of injured workmen) which traditionally has been a responsibility of the States. (2) The further extension of social security benefits to injured workmen will needlessly aggravate and multiply tax free benefits (social security plus workmen's compensation) in excess of wages earned before injury, with obvious reluctance to return to their jobs. (3) The extended benefits will entail enormous administrative detail and expense which, with the benefits paid, will still further burden the already overloaded social security program. The result will be increased social security taxes on both employer and employee.

We are definitely opposed to the inclusion of section 303 into the "medicare" bill (H.R. 6675).

Respectfully submitted,

ROLLA L. JOHNSON,
Vice President and General Manager.

SHEPLEY, SEVERSON, BEY & OCHS,
ATTORNEYS AT LAW,
Edina, Minn., April 21, 1965.

Hon. HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: I trust that I am voicing the opinion of the great majority of your constituents in urging the elimination of section 303 from the medicare bill. Is there any other edifice in the entire bulwark of the American law and jurisprudence that stands out more clearly than the workmen's compensation statute and the relief which it has afforded workers of America for job-connected disabilities and the rehabilitation program which private industry has wholeheartedly supported?

I respectfully urge that you consider the harm that would be done by Federal duplication of workmen's compensation benefits.

There is no dispute but what an employee who sustains a job-connected disability should be compensated for that disability and that he should likewise accept rehabilitation where it is possible to effect same and return to sustained gainful employment.

It appears to me that this particular section 303 of the medicare bill, if passed, would emasculate the entire purpose and objective so signally successful over the more than 50 year existence of the workmen's compensation law. Is there any real gain given to the worker by this type of legislation which in effect is affording to the employee a temporary duplication of benefits which, if passed, would no doubt result in most of the States enacting legislation offsetting workmen's compensation benefits to cure the abuses created by social security's overlap?

No matter what your position on the medicare bill may be, I respectfully join the great majority of employers in urging you to eliminate section 303 from that bill.

It is obvious that section 303 will increase claimants by the thousands and complicate the administration of the disability program.

As you know, up to the present time the recipients have been largely long-term cases which the Social Security Administration does not feel require much administrative supervision. There can be no doubt that if the section 303 definition is enacted, there will be large numbers of persons with temporary, short-term disabilities who will become recipients and will have to be contacted on a month-to-month basis to find out if they are still eligible, not to mention the duplication of benefits already being provided under the workmen's compensation laws of the various States.

I trust you will give this particular appendage to the medicare bill your careful scrutiny and because of the abuses to which it may lead, take action to have it deleted from that bill.

Please accept my kindest regards.

Yours very truly,

R. G. SHEPLEY.

RAYNA DRILLING CO., INC.,
Dallas, Tex., April 23, 1965.

Re: H.R. 6675—"Medicare" bill section 303—Extension of social security benefits to the temporarily disabled.

Senator HARRY BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

MY DEAR SENATOR: It has come to our attention with the passage of the "medicare" bill, H.R. 6675, by the House of Representatives that section 303 of the bill would extend disability payments for the temporarily disabled without a corresponding reduction in the existing State workmen's compensation benefits.

The results to us would increase an already existing shortage of labor by providing a means for a man to gain income (without working) in excess of our present wage scale. Ultimately it would force us out of an already depressed industry by the weight of the added taxes that would be necessary to support such a liberal giveaway program.

It will be necessary for the drilling companies to reduce their labor force so that labor overhead, including the workmen's compensation burden, will be decreased.

It should be evident by this letter that our organization is opposed to passage of the "medicare" bill and section 303 in particular.

Respectfully yours,

PAUL LYNCH.

AUBURN, IND., *April 23, 1965.*

Re: Congress H.R. 6675—Social Security Amendments of 1965—providing medicare and greatly broadening the duplication of workmen's compensation and social security benefits.

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR: I am expressing no views whatsoever about the medicare bill generally, but merely calling your attention to one provision which could result in doubling State workmen's compensation benefits—which in the opinion of many employers are already too liberal, and encourage malingering.

This bill has passed the House. With respect to medicare it contains an exclusion of workmen's compensation medical benefits. However, it also unexpectedly greatly broadens the definition of disability. No offset for workmen's compensation is provided against social security disability benefits. This amendment therefore vastly expands the encroachment of social security into the field of work injuries. Are you aware of this amendment?

Under the bill, workmen's compensation would be duplicated by social security in all cases of temporary and permanent total disability lasting 6 months or more. Duplicate payments, however, would begin with the end of the fifth month. Presently social security disability benefits are payable only for permanent total disability.

It seems doubtful that two compulsory statutory systems providing benefits for the same disability will both be permitted to continue for long. The danger to workmen's compensation is obvious, since combined benefits especially at the increased benefit rate provided in the bill would exceed average take-home pay in at least 47 States.

It is expected that your Senate Finance Committee will begin consideration of this bill following the Easter recess. It is most probable that this bill, in some form, will be enacted. To preserve workmen's compensation, the broadened definition of disability under the bill must be eliminated, or an offset provision enacted.

We urge that you and the other members of your committee give serious attention to the elimination of what must be an obvious oversight in the present bill.

Very truly yours,

W. K. SCHAAB, *Attorney at Law.*

LEWIS FOOD CO.,
Los Angeles, Calif., April 19, 1965.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee, Washington, D.C.

DEAR SENATOR BYRD: In reference to H.R. 6675, in my opinion, every effort should be made to eliminate disability amendment in this bill since this would make is possible in many States with joint State and Federal payments to the disabled worker to exceed his average take-home pay and discourage any efforts to get back to work.

It is not now uncommon to interview a worker who is on relief who will ask for part-time since they don't want to disturb their relief payments, and the difference between relief payments and gainful employment payments, after income and other taxes are deducted does not provide sufficient spread to encourage the worker to get off of relief.

This is now being clearly demonstrated in California where our growers are in desperate need of help—where we have thousands of workers capable of doing farm work but refuse to take the job of stoop labor instead of charity checks. Of course, our farm problem was brought about by the fact that the AFL–CIO failed to organize the farmworkers and proceeded to lobby through a bill that eliminated the braceros and have left the farmers without stoop labor, and the citizens will probably be paying 100 percent more for vegetables than they have in the past. My objections, of course, are in regard to H.R. 6675. The information regarding the California farmworker was added for your information.

Yours very truly,

D. B. LEWIS, *President.*

THE GREATER PROVIDENCE CHAMBER OF COMMERCE,
Providence, R.I., April 22, 1965.

Re H.R. 6675, Social Security Amendments of 1965.

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: Several of our members have expressed concern because of liberalization of entitlement to disability benefits under the above mentioned bill. They are primarily concerned because of employees receiving workmen's compensation.

The bill eliminates present requirement that a worker's disability must be expected to result in death or to be of long continued and indefinite duration and instead provides that the worker would be eligible if he has been totally disabled for a period of 6 months.

Under Rhode Island law claimants for workmen's compensation are also entitled to temporary disability insurance payments. The present limitation on combined benefits is 85 percent of the worker's gross average weekly wage with a maximum of $62 in addition to any dependency payments which can amount to another $12.

When this combination of employer-employee financed benefits on the State level is added to the proposed liberalization of entitlement to benefits under the social security amendments, it is evident that all incentive to return to useful employment is eliminated.

Several of our members have suggested that the above mentioned social security amendments be further amended to exclude workmen's compensation claimants from the disability provisions of the program until they have exhausted their workmen's compensation benefits.

Sincerely,

ROBERT A. PEIRCE,
Manager, Governmental Affairs and Education Department.

WINCHESTER MEMORIAL HOSPITAL,
Winchester, Va., April 16, 1965.

Hon. HARRY F. BYRD, Sr.
U.S. Senator,
Washington, D.C.

DEAR SENATOR BYRD: Our mutual friend John McL. Adams, M.D., suggested I write you in regard to H.R. 6675, Social Security Amendments of 1965.

This proposed legislation has a certain provision that appears to have the potential of reducing and/or adversely affecting the high standards of care now enjoyed by patients in the Nation's hospitals. The particular provision is under "Part C: Miscellaneous Provisions, Definitions of Services, Institutions, Etc.," section 1861, inpatient hospital services, (b)(4). This provision states "excluding, however * * * (4) medical or surgical services provided by a physician, resident, or intern * * *".

The Winchester Memorial Hospital has gained a widespread reputation for the excellency of medical treatment and hospital care. This position is the result of the work of many dedicated laymen and physicians, such as John McL. Adams, M.D. The department of pathology and radiology are very highly regarded because of the most outstanding medical supervision of the work in the departments by physicians who are expert in their respective fields of medicine. The department of anesthesiology under the direction of a well qualified medical anesthesiologist has contributed materially to better patient care.

In order to be specific as to how these departments are operated and how this proposed legislation will affect the normal operation, I will discuss each department in some detail.

The department of anesthesiology is composed of two medical anesthesiologists and five nurse anesthetists. As a rule during the schedule of operations the medical anesthesiologists administer anesthesia to patients. In addition, they devote part of their time to the supervision of the certified registered nurse anesthetists and the students who are learning to be nurse anesthetists. This is a most satisfactory type of arrangement that assures all patients of receiving good anesthesia services. The reason the Winchester Memorial Hospital sought medical anesthesiologists some years ago was to provide even better patient care. The hospital could, of course, operate without medical anesthesiologists supervising all the anesthesia administered but such loss would adversely affect patient care. From the standpoint of mechanics of billing it would appear to be almost impossible for the medical anesthesiologist to submit a fair bill to the patient for the supervision provided. When a medical anesthesiologist personally administers an anesthetic he can very easily render a billing to the patient for the service.

The department of pathology has a staff of 2 medical pathologists and 37 other persons including technicians, students, and secretarial staff. This department includes clinical pathology and tissue pathology. The technicians and other personnel are supervised by the pathologists who are physicians with special training in pathology. From a practical standpoint well over one-half of the pathologists' time is spent in supervision. Last year the pathology department of the Winchester Memorial Hospital performed over 155,000 tests of various types on patients. The presence of excellent supervision assures the physicians on the staff, who order the tests on patients, that the results will be consistent with the practice of good medicine. Under the proposed legislation the Winchester Memorial Hospital could not include the remuneration of these pathologists in the daily costs. Further, it would appear to be extremely impractical for the supervision to be billed separately from the hospital bill. For example, some lab tests cost $1. The pathologist would have to bill for his portion of the $1 charge which would be extremely impractical and costly.

The department of radiology is composed of three radiologists and other persons including technicians, students, and clerical staff. The Winchester Memorial Hospital had one of the earlier X-ray departments in Virginia and through the years has had a most outstanding department of radiology. The radiologists supervise the work of the technicians and interpret all of the X-ray films taken. In addition to the interpretation of films the radiologists perform fluoroscopic examinations, give X-ray treatments and cobalt treatments. Following their advice the Winchester Memorial Hospital installed a cobalt therapy unit for the treatment of cancer and other conditions. Last year the department of radiology performed over 26,700 tests on patients. Without the immediate services of qualified radiologists the patients of the Winchester Memorial Hospital could conceivably receive less than our desired goal and moral responsibility for good care.

I will now present my objections to the particular provision of this bill.

1. The services of radiology, pathology, and anesthesiology have long been recognized as medical and hospital services that properly belong in the hospital.

2. These services would be less than adequate if experts in these respective fields of medicine were not immediately available in the hospital irrespective of the patient's ability to pay. Under this proposed legislation if a patient did

not take the voluntary supplementary insurance plan it is conceivable that he would not benefit from the knowledge of the specialist in anesthesiology, pathology, and radiology. It is highly possible that physicians not qualified in these fields of medicine may attempt to interpret the various tests and that could be detrimental to good patient care. Further, without the direct supervision of the various technicians by a qualified specialist there could be a deterioration in the quality of the work performed. In addition, unless these specialists are on some type of contractural arrangement with a hospital the medical staff could not be as dependent and demanding for their outstanding services. One can seriously question the effectiveness of these departments that do not have contract physicians in charge.

3. From the standpoint of billing, a patient in the Winchester Memorial Hospital receives one bill for all hospital services. Under this proposed legislation a patient could receive four bills instead of one. This would undoubtedly increase administrative costs very substantially. This would in effect increase the Nation's health bill.

4. The Winchester Memorial Hospital has different arrangements with these specialists that appear to be fair to the patients, the physicians, and the hospital. If this provision is left in and the bill becomes law it will be necessary to renegotiate these contracts.

5. As the bill is now written it would appear that the only contract possible so that supervision would be provided would be one of a lease type. This would mean the hospital would lease the department to the particular specialist and in affect lose all control. These departments are in effect closed departments. The closed management is mandatory because of the supervision necessary to assure good work by the technical personnel. In hospitals such as ours there could be a lot of public indignation against lease-type arrangements since the hospital has been built with substantial individual contributions.

6. This bill would greatly affect Blue Cross and other health insurors who now include services as hospital services. A hospital would in effect be providing only room, board, and nursing care.

Title XVIII—Health insurance for the aged, prohibition against any Federal interference; section 1801 states: "Nothing in this title shall be construed to authorize any Federal office or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided * * * to exercise any supervision or control over the administration of any such institution, agency, or person."

In order to carry out the above provision the bill should make it possible for hospitals and these certain medical specialists to work out contracts on a local basis consistent with the needs of the particular community and hospital. The bill should be so written that the total charges for anesthesiology, pathology, and radiology services would be covered as hospital services when these services are offered as hospital services. In addition, the bill should provide total payment when these services are not provided by the hospital directly. I deeply appreciate the opportunity of presenting this matter as it appears to affect our community and our hospital. If I can be of further service please command my attention.

With kindest personal regards and best wishes,

Yours very truly,

CARL S. NAPPS, *Administrator*,

April 22, 1965.

Re Section 808 of the medicare bill.
Hon. RALPH YARBOROUGH,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: During my lifetime and in particular during the past few years, the degree of Federal intrusion upon private enterprise and the individual has reached alarming proportions. This is resulting in a curtailment of our individual freedoms and will impose undue tax burdens not only upon our citizens of today, but also upon future generations. It is a truism that "The power to tax is the power to destroy."

It is now apparent that some form of medicare will become Federal law. For that reason I shall not direct my remarks to the medicare bill as a whole, but will confine them to a particular section of the bill, section 808.

Section 303 is not even pertinent to the purpose of the medicare bill, but is a nonrelated amendment to the social security disability program. Under the present law, the social security disability program is intended to cover cases of severe, long-term disability. Section 303 would drop this requirement and would make benefits available to workers who have been out of work for 6 months with any medically determinable mental or physical impairment. This would result in thousands of workers collecting not only social security benefits, but also other benefits available through workmen's compensation and other local or employer-financed programs. As a result a person could collect more tax-free dollars for not working than he would have earned on the job prior to his injury or illness. There would be no incentive for rehabilitation under such a program.

Section 303 is just another encroachment following the many other encroachments the Federal Government has taken upon private industry. Section 303 would destroy the workmen's compensation insurance system. If that happens the major impetus for occupational safety will be destroyed. Workmen's compensation costs are based upon actual loss experience of industry groups and of individual employers. This gives the employer a direct financial incentive to improve job safety, thus reducing the cost of accidents through safety programs, medical programs rehabilitation and other loss control techniques developed by private industry.

Consider also the additional cost section 303 will impose upon private industry and all of the American people. I need not point out the continual rise in social security taxes during the past several years, and I am sure you are familiar with the future increases that will be necessary to meet the present social security payments, not to mention the additional program of medicare. All so-called Government benefits are charged back to the public in the form of taxes, whether they be called income taxes, FICA, or what have you. Unfortunately, the cost is much greater than the benefit received.

How much additional cost will section 303 of the medicare bill, H.R. 6675 impose upon us? How much wider will section 303 open the door for Federal intrusion? Nobody knows for sure. Section 303 is being rushed through Congress on the coattails of the medicare bill, without public hearings, and with utter disregard for the disastrous effect it will have upon the established programs of private enterprise.

I urge you to work toward the elimination of section 303 from the medicare bill.

Yours very truly,

TONY DIRKSMEYER.

U.S. SENATE,
Washington, D.C. April 24, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate
Washington, D.C. 20510

MY DEAR HARRY: With further reference to our recent exchange of correspondence, I send you herewith a proposed amendment to the social security bill, H.R. 6675. The amendment would provide that, for the purposes of determining whether the earnings of an individual receiving social security retirement benefits exceed the limits prescribed by law, the value of meals and lodging provided by and for the convenience of his employer would not be taken into account. As you know, this amendment would bring the earnings definition under the social security law in line with the income definition as contained in the income tax laws.

I would appreciate it if you would bring the amendment to the attention of other members of the Senate Finance Committee when considering H.R. 6675. I will, of course, personally talk with you about the amendment at the first opportunity. If you need any further information regarding the amendment, please advise me.

With warmest personal regards, I am

Very sincerely,

LISTER HILL.

Enclosures: (1) Draft of amendment and (2) copy of original letter from James W. Wilson, administrator, Piedmont Hospital and Nursing Home, Piedmont, Ala.

AMENDMENT

Intended to be proposed by Mr. Hill to 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, viz: On page 218, between lines 19 and 20, insert the following:

(b) Section 203(f)(5)(C) of such Act is amended by adding at the end thereof the following new sentence: "For purposes of this subsection, there shall not be included as part of an individual's wages remuneration received by him in the form of meals or lodging if such remuneration is excluded form the gross income of such individual under section 119 of the Internal Revenue Code of 1954."

On page 218, line 20, strike out "(b)" and insert in lieu thereof "(c)".

On page 218, line 20, strike out "subsection (a)" and insert in lieu thereof "subsections (a) and (b)".

PIEDMONT HOSPITAL AND NURSING HOME,
Piedmont, Ala., February 24, 1965.

Hon. LISTER HILL,
U.S. Senate
Washington, D.C.

DEAR SENATOR: The board of trustees of the local hospital, has been confronted with a problem that appears to be detrimental to employees 65 years of age and over that are drawing social security benefits.

In the implementation of the Social Security Act, a person that is drawing these benefits is not allowed to make over $1,200 per year without a check or checks being withheld by HEW to be within the $1,200 limit. This part is reasonable, as the drawee is gainfully employed to supplement his income. The part that appears unreasonable is, "that people in this category are penalized for having received meals given by their employer which is for the benefit of the employer." These meals are charged to the person as earned income for social security purposes. The W-2 forms will show FICA taxable wages $1,350, wages for income tax $1,200 because during the year the employee has been given meals in the amount of $150, solely for the benefit of the employer.

Over the United States there are probably thousands of persons employed by hospitals, hotels, cafes, and other public places that are in the age category above, that are given one meal per day per employee. This is for the benefit of the employer and the public, whereby services to the public are not interrupted. Each is being penalized by "a gift" that is to the interest of the employer as the excess of $1,200 is charged to the employee although it is a gift.

For practical purposes and for the benefit of the people in the above category it appears that the Social Security Act should be amended to read as the Internal Revenue Service Act, "that if an employee is given meals and lodging expressly for the interest of the employer, then that value given is not considered as taxable income."

The board of trustees has discussed this with local, State and regional social security offices and find that this is the law. If this is changed it will have to be done by Congress. To benefit the persons this was written to aid, it appears that a change should be considered.

Please give this your serious consideration and if you agree that the persons in the category should not be penalized by a gift, it will help numbers of persons if you will set the machinery in motion to amend the law.

Thank you for your consideration.

Very truly yours,

PIEDMONT HOSPITAL BOARD OF TRUSTEES,
S. G. WOODDY, *Member.*

STATEMENT OF AMERICAN SOCIETY OF INTERNAL MEDICINE, SUBMITTED BY DR. FRED RICHMOND

Beckley, W. Va., April 20, 1965.

Hon. ROBERT C. BYRD,
Senate Office Building,
Washington, D.C.

DEAR SIR: Enclosed herewith is a statement by the American Society of Internal Medicine of which I happen to be a member, and which I wish and hope

that you will find the time to pursue, fairly carefully, and let me know your reaction to its content.

I have studied the transcript, enclosed, fairly carefully, and I see no reason that the suggestions made are not within the desires that all of us want in regard to medical care for the aged. It seems to me particularly desirable that the comment on H.R. 6675, part B, "Supplementary Health Insurance Benefits" are apropos and have far reaching significance. The fear of domination of personal medical care by the Federal Government is not without some foundation and any method, equitably delineated, that will obviate this fear must, therefore, be well founded. I would direct your attention to the present situation that is prevailing in Britain today. The possibility of a strike, certainly on the part of all general practitioners, is definitely possible. More importantly, however, has been the affect on enrollment in medical schools, and the gradual diminished supply of physicians to Britain itself. I have had a number of discussins with British emigres, who are presently practicing in this area, and they are only part of the number who are almost daily or monthly leaving Britain for other areas in the world. Australia, Canada, the United States, South Africa, etc. One estimate by a knowledgeable individual is that within a period of 10 years if the present system continues, that there will probably be less than half the number of physicians presently practicing in Britain, and the number of qualified applicants for medical school will concomitantly drop as well. Historically, the development of such a program as is presently contemplated will never be terminated unless revolution develops, and particularly is this true in a nation the size of the United States. It therefore behooves you, our representatives, to be as deliberate, as sagacious and as prescient as possible in developing this total program. That is my reason for asking that you pursue this enclosure to see if you do not agree that these suggested amendments will only add to the strength and workability of the total program.

Thanking you for past favors, and hoping that you can see fit to support the presently recommended amendments, I am

Sincerely yours,

W. FRED RICHMOND, M.D.

AMERICAN SOCIETY OF INTERNAL MEDICINE,
San Francisco, Calif., April 8, 1965.

To the Members of the U.S. Senate:

The American Society of Internal Medicine is a national organization, with 8,000 members who are all qualified internists. The purposes of the society are "to study the scientific, economic, social and political aspects of medicine at a national level, in order to secure and maintain the best patient care and the highest standard of practice in internal medicine."

But these stated purposes are far less important than the traditional concern of the practicing physician with his sick patients and with the quality of care they receive. It is this concern which has stirred the interest of the members of this organization in the proposed medicare bill. Internists provide nonsurgical services which will comprise the bulk of care rendered under a medicare law, and their sick patients will therefore receive many of the benefits. The members of this organization consider that they have a common interest with each U.S. Senator and each Representative in the Congress in their desire to be sure that the care provided is of the highest quality. For this reason the American Society of Internal Medicine feels an obligation to speak up at this time and share its views with the members of the U.S. Senate.

This society therefore urges that all Senators and Members of the House of Representatives carefully consider the medicare bill. Especially we are concerned with the implication for the future of patient care in this Nation contained in the proposed title XVIII of the Social Security Act as introduced in H.R. 6675. The bill makes provision for Government subsidy of hospital, nursing home, and professional care for individuals over 65 regardless of their financial need. The bill also clearly gives to the Secretary of the Department of Health, Education, and Welfare, the ultimate authority to determine the nature of, the quality of, and the payment for, whatever services are to be rendered. This is a clear departure from the American system of medical care which has become the envy of the other systems throughout the world.

The American Society of Internal Medicine heartily approves what is understood to be the plan of the Senate to hold open discussion and public hearings which have always been customary for such an important, costly and far

reaching measure. The Society hopes to be heard at that time, and further, that its suggestions for improvements in the Bill will receive consideration.

The American Society of Internal Medicine would like to make the following comments with respect to H.R. 6675, for consideration by members of the United States Senate. These comments refer principally to the proposed Title XVIII to be added to the Social Security Act and entitled "Health Insurance for the Aged." They are based upon the assumption that (1) tax-supported medical care will no longer be limited to those in financial need, and (2) the principle that there should always be the greatest possible local and State control of federally supported health care programs will no longer apply.

H.R. 6675, PART A—"HOSPITAL INSURANCE BENEFITS FOR THE AGED"

If it is decided by the Administration and the Congress that the Federal Government will provide payment for medical care for certain individuals whether they need it or not by means of a Social Security payroll tax, then the American Society of Internal Medicine believes that the benefits so provided should be limited to domiciliary care in a hospital, nursing home or similar facility. This Society believes that Representative Wilbur Mills and the members of the House Ways and Means Committee have made distinct improvements over HR 1 and SB 1 in this section. However, it would strongly recommend the total exclusion of benefits for professional and diagnostic services from this section. This would complete what appears to have been the desirable intent of the House Ways and Means Committee. If the hospital benefits under this section are restricted to "domiciliary" care then they would more or less parallel the concept of the Social Security cash payments. Thus they would serve as a base upon which an individual could add whatever is needed to build up an adequate program for his own needs, just as the Social Security retirement benefits serve as a base for an individual's program for financing his retirement.

H.R. 6675, PART B—"SUPPLEMENTARY HEALTH INSURANCE BENEFITS FOR THE AGED"

The American Society of Internal Medicine has its greatest concern and apprehension with respect to the "Supplementary Health Insurance Benefits for the Aged" section of H.R. 6675. The intent to provide a voluntary program with benefits to supplement the basic compulsory program of domiciliary care is most commendable. However, it appears to knowledgeable persons in our society that this section as conceived and written will prove quite unworkable without rather precise regulation and control on the part of the Secretary of Health, Education, and Welfare. This inescapably raises the specter of eventual domination of medical care in this Nation by the Federal administration through the office of the Secretary of Health, Education, and Welfare or an office responsible to him. The quality of medical services would then become the responsibility of the Federal Government rather than of those who render the services. It is the belief of this society that neither the American people nor the U.S. Senate wish this eventuality to come to pass.

If it is to be the decision of the Congress to provide Federal financial support of medical services for those over 65, whether on a voluntary basis or not, or whether in financial need or not, then the American Society of Internal Medicine suggests that this be done thruogh a mechanism similar to the Federal Employees Health Benefits program which has proven to be so successful. This program has now gained a substantial amount of professional and actuarial experience. It has been found to be a workable program which has been satisfactory, not only to the Federal Government, but to physicians and patients as well. This might provide a happy solution with which the medical profession, the sick patients and the Government could live in harmony.

If this is to be done, the American Society of Internal Medicine would like to suggest to the Congress that there be established some sort of a health benefits commission, or board, perhaps with representation from the medical profession, various insurance carriers, and the consumer as well as from Government. Such a commission or board could operate the program in similar fashion to the Civil Service Commission operation of the Federal health benefits program. It should be of quasi-independent status. This would remove the fear of domination of peirsonal medical care by a powerful Federal agency, and would make the same kind and quality of medical care available for all. Most importantly, it would leave responsibility for the control of quality and cost with those who actually provide and render the care.

H.R. 6675, AMENDMENTS RELATING TO IMPROVEMENT AND EXTENSION OF THE KERR-MILLS PROGRAM

This section of the bill, together with the subsequent section III, "Child Health Program Amendments," appear to the American Society of Internal Medicine to be improvements in these programs for the needy which are long overdue. However, there has not yet been an opportunity to study them in detail.

IN SUMMARY

The officers and trustees of the American Society of Internal Medicine speaking for 8,000 qualified internists in this Nation, respectfully suggest:

(1) That ample opportunity be given for public hearings as well as careful review and study of the provisions of this most complex and far-reaching bill.

(2) that all professional and diagnostic services be deleted from that part of the bill which, in part A, provides "Hospital Insurance Benefits for the Aged" by means of a social security tax, and

(3) that serious consideration be given to improving the section of the bill entitled "Supplementary Health Insurance Benefits for the Aged" as presently outlined in H.R. 6675. The American Society of Internal Medicine believes that this can best be achieved under a plan parallel in structure and function to the eminently successful Federal Employees Health Benefits program. The American Society of Internal Medicine further believes that the program should be administered by some sort of quasi-independent health benefits commission or board with appropriate representation which would remove the fear of domination of personal medical care by a powerful Federal agency and make the same kind and quality of medical care available to all.

THE COUNCIL FOR HOMEOPATHIC
RESEARCH AND EDUCATION, INC.,
New York, N.Y., April 21, 1965

Re S. 1: H.R. 6675 "medicare" bill.

To Hon. Harry Flood Byrd,
Chairman, Committee on Finance, U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: This organization respectfully protests against the exclusion of the official Homoeopathic Pharmacopoeia of the United States from the list of compendia contained in the definition of the terms "drugs" and "biologicals" as recited in subsection (t) of section 1861, title XVIII of the above bill now under consideration by the Senate Committee on Finance.

We hope this discrimination against those who wish homeopathic medical treatment can be corrected before the bill is voted on in the Senate.

Sincerely yours,

CONSTANTINE SIDAMON-ERISTOFF,
President.

FEDERATION OF JEWISH AGENCIES OF ATLANTIC COUNTY,
Ventnor City, N.J., April 22, 1965.

Senator HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: H.R. 6675 is an excellent measure. May I ask that you consider two changes.

From an administrative point of view, it would appear to be desirable to have the cost of hospital services of radiologists, pathologists, physiatrists, and anesthesiologists included under hospital costs provided in the bill, and further, that the payments requested of $40 for hospitalization, $20 for diagnostic service, and $50 for doctors' bills, be eliminated. Our experience in New Jersey, where I serve as chairman of the Committee on Financial Assistance of the New Jersey State Board of Public Welfare, has indicated that such provisions are confusing, often conflicting, and are administratively more costly to enforce than the funds that are saved.

This was our experience in implementing the Kerr-Mills program, for medical assistance for the aged in New Jersey. I am quite certain that it would be even more difficult to try to do so on a national basis.

Furthermore, the hospitals, in the first instance, would have to re-do their own statistics as to daily costs, etc., for Blue Cross and others, if the specialists' services are not included as part of the hospital costs. As regards public assistance clients, the State would have to absorb the payments listed above and provide for a very complex bookkeeping operation.

I am mindful of the intent behind the recommendation for these payments. It would seem to me that the purposes could best be served by a much closer supervision and review process.

A great and historic forward step will be taken when your committee completes its deliberations and substantially approves H.R. 6675.

Most sincerely yours,

IRVING T. SPIVACK,
Executive Director.

BURROUGHS WELLCOME & CO. (U.S.A.), INC.,
Tuckahoe, N.Y., April 22, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee, Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I understand that your committee is now taking under consideration the Social Security Amendments of 1965, H.R. 6675, 89th Congress, passed by the House on April 8. I would like to comment upon this bill as it would affect the supply of drugs under the Federal health care program for persons over 65. Two provisions of the proposed bill could have the unfortunate consequence of limiting the drugs available to patients under the "medicare" program.

Section 1861(t) of the bill would permit reimbursement only for drugs included in the U.S. Pharmacopoeia, the National Formulary, New Drugs or Accepted Dental Remedies, or approved by the pharmacy and drug therapeutics committee of the medical staff of a hospital cooperating in the program.

These compendia are concerned mainly with individual drugs. They do not include many therapeutic drug combinations which have found wide usage in medicine because of their effectiveness and simplicity of administration as well as the economy afforded by having the ingredients combined in a single dosage form. In addition to depriving the patient of many new drug combinations now widely used, the publication schedules of these compendia may lead to delays in the listing and availability of approved individual new drug products. Of the 113 products in our present price list, 59 do not appear in these compendia. Among those excluded are a leading prescription analgesic, which has been used by the medical profession for over 37 years; the majority of our topical, otic, and ophthalmic antibiotic combinations which are issued under the certification procedure of the Food and Drug Administration; a long-established preparation for the treatment of coronary conditions and a new drug approved by the Food and Drug Administration for use in the treatment of a certain type of cancer. Unless approved by a local hospital therapeutics committee, these and other useful medicines would be denied to the "medicare" patient. The provision for approval by the local hospital committee would not be expected to cure this defect. Individual action by local committees would probably result in lack of uniformity of drugs available in different hospitals. Many hospitals do not have such committees, and since the committees themselves have a varying degree of expertise in evaluating therapeutic products, factors other than the effectiveness, quality, and safety of the drugs involved may enter into their decision.

Of necessity this could result in interference with the physician's right to prescribe for his "medicare" patient the same drugs he would use for the treatment of his other patients.

Accordingly, we favor amending section 1861(t) by deleting the words "Or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of a hospital furnishing such drugs and biologicals" and substituting "or are ordered or prescribed by the attending physicians on the medical staffs of hospitals for the care and treatment of patients."

Similar objections with respect to the availability of drug products arise under sections 1814(b) and 1861(v)(1) dealing with reimbursable cost, which empower the Secretary of Health, Education, and Welfare to exclude certain drugs from the "medicare" program on the basis of their cost alone, despite the fact that effectiveness and quality should be the principal concern. Consideration of the reasonableness of cost is essential to the effective implementation of the

"medicare" program, but it would seem that the addition of the following language to section 1861(v)(1) would accomplish the desired result.

"*Provided, however,* That charges for items or services furnished a patient shall be deemed to be reasonable if they are ordered or prescribed by the patient's physician for medical reasons, and if such charges do not exceed the customary amount charged by the provider of services to persons not subject to this title."

I urge that these sections be redrafted to assure that no drug the physician deems desirable for his patient will be denied him and that the same standard of care will be available to every "medicare" patient.

Sincerely,

W. N. CREASY, *President.*

WESTINGHOUSE ELECTRIC CORP.,
Sunnyvale, Calif., April 23, 1965.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee, U.S. Senate,
Washington, D.C.

DEAR SIR: One of the most undesirable and harmful points of legislation in the eyes of private industry is that portion of the medicare bill liberalizing the definition of "total disability."

As a California employer, we find an ever-increasing tendency for employees incurring on-the-job injuries to remain away from work for periods far in excess of the period needed for medical recovery. This has been brought about by the increase of State unemployment compensation disability benefits beyond the maximum provided by the California workmen's compensation law and the ever-continuing liberalization of the referees of the industrial accident commission. Many injuried employees are financially better to remain away from work and collect the two benefits referenced above.

If the liberalized definition of "total disability" is allowed to be put into H.R. 6675, it will encourage more and more industrially injured to prolong their recovery period in order to qualify for the additional social security benefit. This will not only add substantially to our already excessive compensation costs but will be a very bad psychological factor for the workingman.

Your efforts in preventing this provision from getting into H.R. 6675 are sincerely requested.

Yours very truly,

IRVING F. ALLEN,
Supervisor, Workmen's Compensation.

WISCONSIN COUNCIL OF THE BLIND, INC.,
Madison, Wis., April 24, 1965.

Senator BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD AND MEMBERS OF THE SENATE FINANCE COMMITTEE: This organization, which represents approximately 1,200 visually handicapped citizens of Wisconsin, wishes the committee to know that sentiment here is strongly in favor of incorporating in the current social security bill the last section of Senator Tower's bill S. 940. The provisions contained in this section were adopted as part of the social security bill in the last session but, as you know, this bill died in conference. We join with many other organizations of and for the blind in urging you to give this matter your most serious consideration.

Respectfully yours,

GEORGE CARD, *Executive Secretary.*

GREENWICH, CONN., *April 26, 1965.*

U.S. Senator HARRY F. BYRD,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: Since you are chairman of the Senate Finance Committee, and I know your great interest in sound and fair legislation, I strongly urge you to eliminate the amendment on disability benefits.

The proposed amendment would permit a temporarily disabled worker to receive dual benefits which in many cases would produce more than the worker's take-home pay if he were working. This is so patently wrong that it must have been an oversight when passed by the House. I understand, for instance, that a married man with two children, earning $5,000 per year, would receive $6,201.60 in tax-free benefits under the proposed admendment, as follows:

Earning while working:	
Gross wage	$5,000.00
Federal income tax	286.00
Social security tax	174.00
Total	460.00
Net pay after taxes	4,540.00
Benefits while disabled:	
Workmen's compensation ($60 per week)	3,120.00
Social security disability benefits	3,081.60
Total tax-free benefits	6,201.60

I trust you will study this costly amendment with care and act to prevent the further extension, in this unreasonable manner, of social security into the workmen's compensation field, which has been operating successfuly over a period of 50 years.

Respectfully yours,

CURTISS E. FRANK.

STATE OF OREGON,
STATE INDUSTRIAL ACCIDENT COMMISSION,
Salem, April 26, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: We, the commissioners of the Oregon State Industrial Accident Commission, respectfully request that you give careful consideration to section 303 of H.R. 6675. This section is a nonrelated amendment to the social security disability program and is not pertinent to the medicare program.

The encroachment of the social security disability program through the overlap of disability payments to permanently and totally disabled workmen's compensation claimants has had a hampering effect on efforts to improve workmen's compensation benefits. If social security is allowed to further invade the workmen's compensation system through payments for time loss for occupational injuries, it will be impossible to increase workmen's compensation benefits to keep up with the need.

We respectfully direct your attention to the danger to safe working conditions. The outstanding records in safety of today as compared to the times before workmen's compensation are clear proof that workmen's compensation has given greater impetus to safety than anything else. Records will show that the graduated premium rates, reflecting the effectiveness of employers' safety efforts, have saved untold numbers of occupational injuries and fatalities.

All this will be lost if social security is allowed to absorb workmen's compensation. There is no distinction in social security payments made by employers that reflects the degree of hazard or the efforts made to reduce injuries to their workmen. This powerful incentive which is fundamental to workmen's compensation is totally lacking in social security. It is inevitable that occupational injuries will increase.

To combat that unwanted condition it is almost certain that there will be a demand for the return of common law rights of the workman to sue his employer. This system was never satisfactory to the workers and would benefit only attorneys, while costing the public huge sums in providing the courts.

We respectfully request that you use your influence to have section 303 amended in such a way that disability payments do not apply to workmen's compensation claimants. Efforts are being effectively made to upgrade workmen's compensation benefits now. Let us not nullify the system of having payments

to workmen's compensation claimants paid as a cost of production to the employing entity and also tailored to encourage safety.

Thank you for your consideration.

Respectfully yours,

CHARLES B. GILL, *Chairman.*
WM. A. CALLAHAN, *Commissioner.*
WILFRED A. JORDAN, *Commissioner.*

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., April 8, 1965.

HON. HARRY F. BYRD,
Chairman, Committee on Finance,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: It has come to my attention that under the present program for medical care for the aged about 2 million persons will be covered by the proposed legislation who are not now insured. It would seem to me that the principles contained in Public Law 87-693, with reference to the recovery of tortiously liable third persons, might be incorporated into the medicare bill now pending in your committee. As you will remember you were the author in the Senate of 87-693.

As you know, the House is debating the bill with a no amendment provision, and I wondered if you might consider the possibility of adding the concept contained in Public Law 87-693 to the Senate version of the bill. A copy of a proposed amendment and a copy of 87-693 is attched for your consideration.

With kindest regards,

Sincerely,

CHARLES E. BENNETT.

Enclosures.

MEDICARE BILL, P. 107, SECTION 103(D)

Notwithstanding any other provision of this act, or any other provision of law, the Secretary is authorized, with respect to any payment made to a provider of services on behalf of an individual whose entitlement to monthly insurance benefits under section 226 of the Social Security Act is authorized under section 103 of this act, and whose illness or injury was caused under circumstances creating a tort liability upon some third person (other than or in addition to the United States) to pay damages therefor, to recover from said third person any payment thus made and, for purposes of effecting such recovery, the provisions of the act of September 25, 1962 (Public Law 87-693, 42 U.S.C. secs. 2651-2653) shall be applicable to the same extent as if the United States had furnished the hospital and medical care and treatment to such individual under authorization or requirement of law; and all amounts so recovered shall be returned to the Federal hospital insurance trust fund established by section 1817 of the Social Security Act.

Public Law 87-693 87th Congress, H.R. 298 September 25, 1962

AN ACT[1]

To provide for the recovery from tortiously liable third persons of the cost of hospital and medical care and t eatment furnished by the United States

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) in any case in which the United States is authorized or required by law to furnish hospital, medical, surgical, or dental care and treatment (including prostheses and medical appliances) to a person who is injured or suffers a disease, after the effective date of this Act, under circumstances creating a tort liability upon some third person (other than or in addition to the United States and except employers of seamen treated under the provisions of section 322 of the Act of July [illegible] 1944 (58 Stat. 696), as amended (42 U.S.C. 249) to pay damages therefor, the [illegible]ited States shall have a right to recover from said third person the reasonable value of the care and treatment so furnished or to be furnished and shall, as to this right be subrogated to any right

[1] (S. Rept. 1945), overrule, *U.S. v. Std. Oil Co. of Calif.*, 332 U.S. 301 (1947).

or claim that the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors has against such third person to the extent of the reasonable value of the care and treatment so furnished or to be furnished. The head of the department or agency of the United States furnishing such care or treatment may also require the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, as appropriate, to assign his claim or cause of action against the third person to the extent of that right or claim.

(b) The United States may, to enforce such right, (1) intervene or join in any action or proceeding brought by the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, against the third person who is liable for the injury or disease; or (2) if such action or proceeding is not commenced within six months after the first day in which care and treatment is furnished by the United States in connection with the injury or disease involved, institute and prosecute legal proceedings against the third person who is liable for the injury or disease, in a State or Federal court, either alone (in its own name or in the name of the injured person, his guardian, personal representative, estate, dependents, or survivors) or in conjunction with the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors.

(c) The provisions of this section shall not apply with respect to hospital, medical, surgical, or dental care and treatment (including prostheses and medical appliances) furnished by the Veterans' Administration to an eligible veteran for a service-connected disability under the provisions of chapter 17 of title 38, United States Code.

SEC. 2. (a) The President may prescribe regulations to carry out this Act, including regulations with respect to the determination and establishment of the reasonable value of the hospital, medical, surgical, or dental care and treatment (including prostheses and medical appliances) furnished or to be furnished.

(b) To the extent prescribed by regulations under subsection (a), the head of the department or agency of the United States concerned may (1) compromise, or settle and execute a release of, any claim which the United States has by virtue of the right established by section 1; or (2) waive any such claim, in whole or in part, for the convenience of the Government, or if he determines that collection would result in undue hardship upon the person who suffered the injury or disease resulting in care or treatment described in section 1.

(c) No action taken by the United States in connection with the rights afforded under this legislation shall operate to deny to the injured person the recovery for that portion of his damage not covered hereunder.

SEC. 3. This Act does not limit or repeal any other provision of law providing for recovery by the United States of the cost of care and treatment described in section 1.

SEC. 4. This Act becomes effective on the first day of the fourth month following the month in which enacted.

Approved September 25, 1962.

This amendment provides that where hospitalization benefits are paid out of the general revenues of the Treasury on behalf of a person who is not entitled to social security benefits, for an injury or illness caused by a tort, the Secretary of HEW is authorized to recover the cost of such benefits from the person causing (or contributing to) the tort and to pay the recovered amount into the hospital insurance trust fund.

(I believe a conforming amendment should be made to sec. 103(c) to reduce the amount of the appropriation by the amount recovered under this amendment.)

MARCH 3-26, 1965.

Congressman Bennett now says in his view it should be applied both to amounts paid through the general revenues and to amounts paid through the social security tax. It would have to be redrafted to accomplish this, though.

PROVIDENT MUTUAL LIFE INSURANCE
COMPANY OF PHILADELPHIA,
Philadelphia, Pa., April 27, 1965.

H.R. 6675—Social Security Amendments of 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: I am writing to express some concern about this bill which has been passed by the House and is now under consideration by the Senate

Finance Committee. I am quite aware that it may be entirely fruitless to argue against passage of any medicare legislation whatsoever, but it does seem to me that if the legislation is to be enacted, there are certain fundamental objections to the present bill which should be corrected.

First, with respect to the supplemental medical care benefits for persons over 65, I am afraid that these provisions would seriously narrow and perhaps almost eliminate the field for voluntary health insurance coverages offered by private insurance companies to persons over 65. I believe this is contrary to the spirit of the President's 1965 health message which advocated that insurance companies should play a major role in providing voluntary health coverages.

For this reason I believe that the provision for the optional supplemental benefits should be eliminated. However, assuming that the Congress should refuse to eliminate this provision, then I think the optional feature violates a fundamental principle of social insurance. This is because it is offered on an optional basis, subsidized from general tax revenues, and thus would discriminate against persons who could not afford to subscribe for the supplemental coverage.

With respect to the provisions for disability coverage, the bill certainly would invade the field of both short-term and long-term disability coverages now offered by insurance companies, and this again would seriously narrow the field now served by the private insurance companies. Furthermore, the bill contains no provisions to offset benefits provided by State workmen's compensation laws or State cash sickness programs. Thus there could be many situations where there would be duplication of benefits, often significant enough to result in greater total governmental indemnity than the employee's monthly earnings prior to disability. Experience shows that where there is a duplication of health insurance benefits, this reduces the incentive to return to work and encourages malingering or a mental attitude that it is easier to receive tax-free benefits than to try to earn taxable wages. Obviously, such duplication can prove quite costly in the operation of any insurance plan.

I would also have serious doubts about the wisdom of increasing the taxable wage base from $4,800 to the projected $6,600 in 1971. It seems to me that the wage base should be more closely geared to current average wages and that it is unsound to freeze into the law an assumption that the average wage will be $6,600 by 1971. Possibly the $5,600 wage base would be reasonable, although I would think that $4,800 would be even more reasonable and more consistent with the social purposes of the legislation.

I apologize for the length of this letter but I found it difficult to condense in any shorter space the points I wanted to bring to your attention.

Sincerely,

T. A. BRADSHAW.

SOUTHINGTON, CONN., *April 13 1965.*

HON. THOMAS DODD,
Senate Office Building, Washington, D.C.

DEAR SENATOR DODD: I urge you to oppose a possible amendment to the present medicare bill which would place radiologists under the directive of the hospital administrator.

Senator Douglas has stated that he would propose such an amendment which would not only eventially ruin the private practice of radiology but would have the immediate effect of dampening any tendency a young medical student might have for our field.

There are 7,000 hospitals in this country with approximately 6,000 certified radiologists. The training of a radiologist is as long or longer than most medical specialities.

Since our services are being utilized more every day as we uncover new diagnostic X-ray and isotope modalities, it would seem that we will need more X-ray physicians in the immediate future.

The amendment to be proposed by Senator Douglas would serve to accomplish the opposite.

I wish to thank you for your consideration.

HARRY H. BROWNE, M.D.

WASHINGTON, D.C., *April 28, 1965.*

HON. HARRY BYRD,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: This is in reference to the Douglas amendment (79) that would include anesthesiologist, patheologists, radiologists, and physiatrists in the medicare bill now under consideration by your Senate committee. I would like to explain why anesthesiologists should be considered differently than these other so-called "anciallary services."

The specialty of anesthesiology (physicians trained in the specialty of anesthesia) is a young one. Its impetus was initiated during World War II. when the Armed Forces realized that technician anesthesia could not cope with the complicated medical problems that demanded comprehensive medical judgment as related to anesthetic management. Many of the more sophisticated operative procedures possible today are only possible because of improved anesthesia techniques devised by physician-anesthesiologists.

Although all medical schools and most large hospitals have physician-anesthesiologists who head their respective departments of anesthesia, our members are too few so technicians are employed in some institutions to supplement anesthesia services. Nevertheless, approximately 85 percent of the physician-anesthesiologists in the United States perform a professional service and render a bill to the patient in the same manner as do surgeons, internists, and obstetricians. Washington, D.C., has been unique in that physician-anesthesia services have been rendered to patients, with rare exception, on a professional basis since 1909.

Many anesthesia programs including our own, have only physicians administering anesthesia in the capacity of staff, residents, or fellows with no nonmedical personnel. Contrasted to this, radiology, pathology, and physical medicine of necessity have to have technicians to accomplish their workload in all institutions. I am not saying that physicians in these specialties do not render a professional service for I feel they do but they are not personally involved in every aspect of every examination done by their departments. Most anestheseologists are (85 percent).

The present medicare bill, without the Douglas amendment, will pay for anesthesia services if it is defined as a hospital service. However, if the Douglas amendment is added to the present bill, the anesthesiologists (85 percent) who are presently engaged in the professional private practice of medicine will be suddenly classified as technicians (nonprofessional service) and subject to nonprofessional governing bodies—the American Hospital Association. This would be a severe demotion to those of us who have been practicing medicine for many years. Further such action would violate the statement in the medicare bill that indicates that its intent was not to interfere, in any way with the private practice of medicine.

In my opinion, the inclusion of the Douglas amendment to the present medicare bill would sound a death knell to the medical specialty of anesthesiology. Why should a graduate of a medical school choose a specialty that is not considered the practice of medicine? I do not think many will. As previously stated, we have a shortage of American medical graduates in our specialty at the present time. This turn of events would seriously hamper our present recruitment program. Further, some anesthesiologists, in active practice would choose some other line of medical endeavor rather than be subjected to the humiliation of rendering a hospital anesthesia service (nonprofessional technician's service) and have such a service be considered along with such items as food cost, depreciation of equipment, etc.

Frankly, I am opposed to the Douglas amendment and sincerely hope that it will be defeated. If, however, your Senate committee seriously considers this amendment, anesthesiologists should be deleted from it, for the reasons I hope I have made clear to you.

If it is possible to arrange a personal meeting with you in the near future, I would like to explain other facets of our specialty that is difficult in a written communication.

At present, I am attending an American Board of Anesthesiology meeting in San Francisco, Calif., but will be home on Tuesday of next week.

Sincerely yours,

WILLIAM E. BAGEANT, M.D.,
Chairman, Department of Anesthesiology, Washington Hospital Center.

I am a registered voter in the Jefferson District, Loudoun County, Va.

RADNOR, PA., *April 28, 1965.*

Social security amendments.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: I am concerned about certain parts of proposed amendments to the social security laws embodied in H.R. 6675, which are currently being considered by the Senate Finance Committee.

The proposals embrace several new concepts which should be implemented cautiously in view of the fact that their future costs and the impact on our citizens are extremely uncertain. For example, under the proposed program of medical and hospital care for the aged, the new concept is that of providing services for conditions determined by judgment as contrasted to paying out cash benefit contingent upon attainment of age 65 or some similar definable event. To guarantee medical services, regardless of their future cash costs and their relation to contributions collected, is a very volatile undertaking and should be implemented in studied steps if at all possible.

A second concept is that of liberalizing the disability insurance provisions to pay benefits for shorter and temporary periods of disability. This new concept creates another ill-defined area of benefit payment and, I believe, should be avoided altogether in view of the present adequate coverage of temporary disabilities by union-employer negotiated plans and other existing arrangements.

Another elusive point is the proposed increase of the taxable wage base as of a date so far in the future as the year 1971. To anticipate $6,600 as being the proper new wage base for that year is not at all wise in my opinion.

Specifically I urge the committee to consider carefully the following:

1. Either fund the supplemental health insurance benefit for the aged by a payroll tax and make it compulsory, or eliminate this provision from the bill.

In its present form this proposal is neither fish nor fowl. It is not a proper social program in that it is not compulsory and will principally be used by those who can afford to pay the optional contribution. Those who do refuse, or cannot pay for, the option will still remain uncovered and dissatisfied. Furthermore, the financing of the Government contribution to the program via general revenue, rather than by a payroll tax, obscures and buries the actual cost. The end result will be a program with which many will be dissatisfied, while the costs will not be appreciated by the public. If one part of aged medical care (hospitalization) should properly be compulsory with payroll-tax financing, why should the other part be an entirely different animal?

Therefore I urge that the supplementary program either be compulsory and financed through a payroll tax or deferred until a more satisfactory arrangement than the proposed one can be drawn.

2. Retain the present disability requirements to qualify for benefits.

The proposed change introduces an element of considerable uncertainty into the administration and the financing of the disability program. Basically I doubt that Government should be working with the multitude of temporary in-and-out types of disabilities which are currently well taken care of either by union-employer agreements or by unilateral employer or employee efforts. The proposed provisions create a frustrating and costly investigating of overlap with workmen's compensation, salary continuance programs, and many other established disability programs already functioning. When the complications of replacing many private programs by a Federal program is stacked up against the financial danger to the social security system, H.R. 6675's disability provisions seem to me entirely inappropriate.

I urge that you seriously consider retaining all the present disability insurance provisions in the social security laws.

3. Provide for any increase in taxes after the January 1, 1966, increase by increasing the tax rate instead of a large increase in the base wage.

Anticipation of a $1,000 increase in the taxable wage base between January 1, 1966, and January 1, 1971, is not justified. In my opinion it is just unnecessary. The safer approach would be to provide for an increase in the tax rate within the proposed taxable wage base, and later amend the law to allow an increase in the wage base as the year 1971 approaches and the wisdom of such a change appears more justified. If the wage base is to represent an approximate average worker's earnings level, we should wait until these averages become reasonably apparent instead of basing our financing assumptions on a presumed $1,000 increase over the 5-year period in question.

I urge that the committee seriously consider providing increased revenues, after the January 1, 1966, increase, from increased tax rates to the $5,600 base, and that any change in the tax base be deferred.

Further, I urge that committee insist that any amendment to the law be drawn to isolate and promptly pay any increased costs and not to defer and pass on to others the debts we incur today.

Very truly yours,

CHARLES E. PROBST.

NATIONAL MEDICAL FOUNDATION FOR EYE CARE,
Washington, D.C., April 28, 1965.

Hon. HARRY F. BYRD,
Chairman, U.S. Senate Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: On behalf of the National Medical Foundation for Eye Care, I would like to take this opportunity to submit for your consideration our views on H.R. 6675, 89th Congress, which would amend the social security law.

1. Section 1802(a)(7) excludes "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." The National Medical Foundation for Eye Care endorses the underlying purpose of these exclusions in the public interest and commends Congress for considering them in its deliberation on these proposed amendments to the Social Security Act.

2. Section 1902(a)(12) of the State plans for medical assistance provision states, in part, that "in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;". It is our suggestion that the section be amended by striking the words "or by an optometrist, whichever."

Whenever blindness exists, it is the result of disease or injury, conditions which can be diagnosed and treated only by a physician. Moreover, we believe that to grant optometrists the right to make examinations for determining blindness can, in individual cases, result in a failure to ascertain the cause of blindness and thus prevent the administration of necessary medical rehabilitative care. The application of medical skills by a doctor of medicine will help insure the detection and successful treatment of the organism and systemic causes of blindness.

We do not believe that it is the intent of Congress that an examination be made solely for "determining whether an individual is blind," but that Congress is properly concerned and desires that such an examination afford an opportunity to determine the true medical cause of blindness and to appraise the chances of rehabilitation or cure. Unfortunately for the blind patient, such diagnosis and treatment cannot be provided by optometrists.

As a national ophthalmological organization with affiliate State ophthalmological societies, we believe that the country will best be served at this time through the utilization of the experience and knowledge of physicians in determining whether an individual is blind. As physicians skilled in diseases of the eye, we are dedicated to the principle that all blind patients are entitled to a medical diagnosis, necessary medical rehabilitative care, and an opportunity to lead a productive wholesome life. Although all physicians are trained in the diseases of the eye, the medical profession as a whole adheres to the principle and supports the practice of examination and diagnosis of the patient with serious impairment by a physician specially qualified in diseases of the eye.

3. Section 1905(a)(12) provides for payment to meet the cost of "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." We wish to emphasize again that all physicians are trained in diseases of the eye, but we note here an apparent intent to exclude eyeglasses prescribed by physicians who do not possess specialist qualications in diseases of the eye. Glasses are prescribed for a significant number of Americans by their family physicians who are fully qualified to render such service. There is no justification for discriminating against these physicians and their patients in this service. We therefore suggest that this section be amended by deleting the words "skilled in diseases of the eye."

4. We note that section 1861(b)(4) excludes payment to hospitals for services to patients by physicians including physicians in radiology, pathology, anesthesiology, and physical medicine. We commend the Congress for its perception in providing for maintaining the distinction between hospital care and physician services. The services that these physician specialists render, like the services of all physicians, are medical services. To have provided for their payment as hospital services would have been to confuse the public and to invite pressure from the patient for hospitalization when such may not be required. We urge the Senate Committee on Finance to reject the proposals to amend H.R. 6675 to, in effect, redefine the services of radiologists, pathologists, anesthesiologists, and physiatrists as hospital services.

I will appreciate your arranging for this letter to be made part of the record of your hearings.

Sincerely yours,

J. SPENCER DRYDEN, M.D., *Vice President.*

AMERICAN ASSOCIATION OF HOMES FOR THE AGING,
New York, N.Y., April 30, 1965.

Hon. HARRY F. BYRD,
Chairman, Finance Committee, U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The American Association of Homes for the Aging is the national membership organization of nonprofit voluntary and governmental homes for the aging. It provides its members with a means of identifying and solving problems of mutual concern and thus protects and advances the interests of the individuals they serve.

This association is pleased to be included in the statement on H.R. 6675 which is being presented before your committee on May 3, 1965, by the chairman of the National Social Welfare Assembly's Committee on Social Issues and Policies.

May we bring to your attention the concern of the many nonprofit homes for the aging in this country which provide the highest caliber of skilled nursing care services to older people. Not only do these institutions qualify, according to the bill's definition, as extended care facilities, but they are, through this association's developing program of approval of health-care facilities, participating in a nationally accepted approval program which will assure the Government, the older person, his family and his community, of the provision of skilled nursing care services.

With this in mind may we comment on that part of the bill dealing with post-hospital extended care benefits. The bill provides these benefits for 20 days in a benefit period, plus 2 additional days for each day of unused hospital benefit up to a maximum of 80 additional days (providing a total maximum of 100 days of posthospital care). May we suggest that the two-for-one ratio, substituting two skilled nursing care days for each day of unused hospital benefit, is not in accord either with the ratio of hospital costs and nursing care costs, nor is it in accord with the long-term care needs of the older person. May we therefore suggest consideration by your committee of modification of this ratio to one whereby three days of skilled nursing care might more equitably be substituted for unused hospital benefit.

We are, as always, eager to be of assistance to you and your committee in your valued attempts to improve care of the older people in this country.

Sincerely,

HERBERT SHORE, *President.*

BOARDMAN, STODDARD & BREUL,
ATTORNEYS AND COUNSELORS AT LAW,
Bridgeport, Conn., April 21, 1965.

Re "medicare."
Hon. THOMAS J. DODD,
Senate Office Building,
Washington, D.C.

MY DEAR SENATOR DODD: As a trustee of Bridgeport Hospital, I am informed that the "medicare" bill as approved by the House removes from coverage under the basic hospitalization program payments for X-ray, pathology, anesthesiology and physical medicine.

Common practice throughout the country has included X-ray examinations, laboratory tests, and the giving of anesthesia during surgery or obstetrical delivery as "hospital services" included in the hospital bill, regardless of the details of financial arrangements between the hospital and the medical specialist rendering the service. The great majority of hospitals and doctors have worked out fair and equitable contracts which are satisfactory to patient, physician, and hospital. The "medicare" bill as approved by the House removes all of these services from "hospital care" and would require that every such service be individually billed by the physician responsible for supervising the program.

If the bill in final form contains this provision, it will force a complete reorganization of the accounting system of every general hospital in the country and will completely disrupt the satisfactory working arrangements between hospitals and doctors. It will be extremely detrimental to the entire Blue Cross movement and create havoc with commercial health insurance plans, all of which are planned to conform to the traditional concept of "hospital care" as distinguished from "professional service."

If passed in its present form, every patient will be confronted with five or six separate bills in addition to the hospital bill, which would then include only hotel services and nursing care. You can imagine the detrimental effect which this will have not only upon the hospital's relations with its patients but probably even more so in the reaction of the patients toward their legislators when they are faced with unnecessary multiple bills for hospital services and are informed that this is necessary only because it is required by the Federal Government.

I trust that you will make every effort to insure that the provision removing such payments from coverage be restored, as the bill with this exception has all the provisions recommended as beneficial to hospitals in providing proper care for their patients.

Very truly yours,

BRADFORD BOARDMAN.

THE UPJOHN CO.
Kalamazoo, Mich., April 30, 1965.

Hon. HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The administration's expanded medicare bill (H.R. 6675), establishing a new Federal hospital and related health care program under social security, passed the House of Representatives without any public hearings this year. We in the pharmaceutical industry, therefore, have not had an opportunity to publicly express ourselves on the actual provisions of this bill which are of concern to us. Apart from the philosophy of the bill itself, it contains two matters which do affect and concern our industry specifically.

1. Under the definition of the term "drugs" and the term "biologicals" appearing in section 1861(t) many drugs, new and old, extensively used by physicians in their medical practice are excluded from the "medicare" program. Under provisions of this section, only such drugs and biologicals are included as are included in the United States Pharmacopoeia or the National Formulary, or in New Drugs, or Accepted Dental Remedies 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.

We feel that this language is unduly restrictive. Such a restriction means that, under the program, beneficiaries will be denied many drugs prescribed for them by their physicians. New drugs, adequately studied and released for use by the Food and Drug Administration, or antibiotics certified as acceptable would not immediately qualify under this section, thus depriving patients and physicians of the use of the latest products of medical research. Considering the advances made in drug research in the past 15 years and their immediate effect on the public health, this section would put a severe limitation on the use of new drugs which represent an immediate and significant advance.

In addition, many fine products used in medicine over a period of years would not qualify on a nationwide basis under the definition simply because they do not meet the specifications of any of the compendia listed or seem important to a particular hospital's committee. Formulations of mixtures of drugs, for example, might be omitted from these lists.

It would appear to us that any product prescribed in good faith by a physician for his patient should be included. It is our suggestion that section 1861(t) be

amended by deleting the words: "or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of a hospital furnishing such drugs and biologicals." and in lieu of this language inserting the words: "or are ordered or prescribed by the attending physicians on the medical staffs of hospitals for the care and treatment of patients."

2. The second provision of the bill of concern to the public is the following:

Section 1814(b) reads: "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)."

Section 1861(v)(1) includes general language which outlines the authority of the Secretary of the Department of Health, Education, and Welfare to promulgate regulations specifying the methods to be used in determining the "reasonable cost" of services.

The above sections establish an arbitrary rule for financing some, but not all, useful drugs. Such authority would enable the Secretary, by regulation, to exclude certain drugs on the basis of cost alone. It could, in effect, restrict the physician's choice in prescribing the products which in a particular case may be the most useful.

In order to ensure that the industry, the pharmacist, and the physician retain the freedom to conduct their affairs in the best interest of the public, we respectfully propose that the following language be added at the end of section 1861(v)(1): "Provided, however, that charges for items or services furnished a patient shall be deemed to be reasonable if they are ordered or prescribed by the patient's physician for medical reasons, and if such charges do not exceed the customary amount charged by the provider of services to persons not subject to this title."

It is our hope that when the Senate Finance Committee takes up this bill that they will give serious consideration to our comments and suggestions.

Sincerely,

E. G. UPJOHN, M.D.

FLORIDA RADIOLOGICAL SOCIETY,
Fort Lauderdale, April 30, 1965.

Senator HARRY F. BYRD,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: It was the unanimous recommendation of the membership of the Florida Radiological Society at our business meeting held in Miami Beach April 24th that you be advised of our vigorous opposition to any amendment to H.R. 6675 which would reinsert the services of radiologists and other physicians into the King-Anderson portion of the bill.

I should like to call to your attention the ruling of the Judicial Council of the Florida Medical Association passed unanimously by the House of Delegates of the Florida Medical Association "that any contract, written or oral, which permits purveyal of the physician's services for profit is unethical; that in the private practice of medicine a contract is only acceptable on a fee-for-service basis; we would also like to reaffirm the ethic that a physician should render the bill to the patient (himself) for his services and his services alone."

It is our sincere hope that you will weigh these factors in your deliberations as a member of the Senate Finance Committee in considering H.R. 6675.

Respectfully,

MARVIN V. MCCLOW, M.D., *President.*

ESCONDIDO, CALIF., *May 1, 1695.*

Senator HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: I am writing in regard to the "medicare bill" recently passed by the House of Representatives and now said to be under consideration by the Senate Finance Committee prior to a vote by the Senate. This bill has many admirable features filling a need which has heretofore not been met. From the standpoint of the medical profession, it would appear that the architects of tis piece of legislation in the House have tried very hard to preserve the independence of physicians in the modification of H.R. 1 which added a supplemental voluntary plan covering physician's services. I am particularly pleased that

the House saw fit to so preserve the independence of all physicians including radiologists, pathologists, anesthesiologists and physiatrists. I am now concerned that the Senate may be swayed by an attempt by the American Hospital Association to reclassify the services of the physicians in these four specialties as hospital services.

Hospital radiologists and physician members of the other three specialties need and deserve independence from hospitals in which they must work (as must surgeons and most all other types of physicians) for the benefit of their patients, their specialties, and themselves. It is true that some such physicians practice on a salaried basis in hospitals, but so do other types of physicians such as surgeons. The vast majority of the physicians in the four specialties the AHA would like listed as hospital services practice under a contract, fee for service basis and a significant number actually bill independently. Unfortunately, except in those instances where such physicians do bill independently, hospitals have increasingly through the years profited on the services of such physicians, this fact being the basis for the desire of the hospital industry to reverse that part of the House bill dealing with radiologists, etc. It is important to realize that this same situation, in addition to frequently being the cause of a lowering of quality of "hospital-professional" services by encouraging a high volume of patients per physician in a monopolistic situation, is also responsible for a decrease in the attractiveness of such important fields to graduating medical students and interns. The specialty of radiology for example is currently seriously falling behind demand in the training of residents and the fact of hospital indenture is unquestionably a major factor. There is no question in my mind that I would have chosen a field other than radiology 12 years ago had I known that it might become a branch of medicine designated in law as a "hospital service".

There is no basis for any fear by the AHA that the provisions of the current House bill would affect the continued development of the modern hospital system. The provisions of the bill would appear to be such that the hospitals would be reimbursed completely for all their costs including equipment replacement and financing of newer, more advanced facilities. Radiologists recognize the need of hospitals to do this and also know that above and beyond these complete costs the hospitals have long taken from the patient without his knowledge an amount equal to 10 to 20 percent and more of the fees in radiology, for example, to cover hospital deficits outside the X-ray departments. Patients are thereby forced to pay for services they may not request or need. Might it not be better for hospitals by careful cost accounting encouraging more efficient management to show true costs of all phases of hospital operation in billing the patient or Government for those services actually supplied each patient?

The nationwide renegotiation of contracts which it is said will be necessary by hospital spokesmen will not be required. For patients covered under the current medicare bill, the hospital will simply receive their cost from the Government and the radiologist, etc., can simply and easily bill separately for his professional services. It should be realized that this may very well bring about a reduction fees in these specialzed services by the amount that the hospitals have for year profited from them. Where certain specialists are on a salaried basis, they could simply assign the payment for their professional services to their employer. After all, what will the hospital system plan to do in the case of employed surgeons in addition to other physicians outside the fields of radiology, pathology, anesthesiology and physiatry?

I respectfully request that you consider the points I have raised above and hope that the Senate Finance Committee will resist the efforts of the American Hospital Association to change the current medicare bill to wrongly classify radiology and these other three specialities as hospital services.

Yours very truly,

WILLIAM R. LETSOH, M.D.

HINKLEY & DONOVAN,
ATTORNEYS AT LAW,
Lancaster, N.H., April 20 1965.

Hon. NORRIS COTTON,
U.S. Senate, Washington, D.C.

DEAR SENATOR COTTON: Regardless of the merits of the medicare bill, I am very much opposed to section 303 thereof relating to social security disability benefits.

This section seems to me to have nothing to do with medical care and will be a further encroachment upon State workmen's compensation laws. You, of course, are aware that already there is some encroachment in case of total disability and section 803 would extend this encroachment by providing social security benefits where the disability is more than 6 months.

In a great many instances, disabled workmen will be receiving more in total benefits than they were able to earn and obviously their incentive to return to useful employment will be greatly reduced.

I hope you will do what you can to delete section 803 from the bill.

With best regards, I am,

Sincerely yours,

WALTER D. HINKLEY.

NEW HAMPSHIRE INSURANCE CO.,
Manchester, N.H., April 10, 1965.

Re H.R. 6675—Social Security Amendments, 1965—duplication of compensation insurance and social security benefits.

Hon. NORRIS COTTON,
U.S. Senate, Washington, D.C.

DEAR NORRIS: For some years a highly inequitable situation has existed under which certain persons who were totally and permanently disabled could collect legally prescribed compensation insurance payment from their employers' insurance companies, and in addition collect benefits for the same injury under the Social Security Act.

Many evils result from this. For example: (1) It discriminates against those who are not entitled to compensation; (2) it places a premium on permanent total disability since the total recoveries exceed wages in many States; (3) it constitutes an encroachment of Federal Government into the insurance business; (4) it furnishes another of the many ratholes for spending taxpayers' money where no such spending is justifiable; (5) it results in two compulsory systems providing benefits for the same injury. Now suddenly and without warning it is proposed to broaden social security benefits to add to the total permanent disability, temporary disability lasting 6 months or more, still with no offset of compensation benefits.

This, therefore, would further worsen the situation.

I strongly urge that the broadened definition of disability under the above bill be eleminated, or an offset of compensation payment provision be incorporated in the bill.

Sincerely,

Clark.

CLARK B. BRISTOL.

STATEMENT OF CALIFORNIA COMMISSION FOR THE ACCREDITATION OF NURSING HOMES AND RELATED FACILITIES

Pending legislation reflecting the increased concern of the Federal Government with long-term medical and/or nursing home care for patients over 65 years of age contains provisions relating to means of determining quality of performance in long-term facilities. The mechanism of accreditation may be proposed as a means of identifying facilities to which payment may be made.

You may realize that accreditation programs for nursing homes and related facilities at the national level are still somewhat unsettled. It is widely agreed that two agencies performing essentially the same function is not only redundant but may even be deleterious to the concept of voluntary accreditation. Undoubtedly amalgamation of the national accreditation programs will come about within a reasonable time, as soon as reconciliation of certain philosophic differences can be attained.

I would like to point out that California already has an accreditation program for nursing homes and related facilities operative for more than 4 years, sponsored jointly by the agencies in the State whose counterparts are failing to agree nationally. We believe that California represents the nidus from which consolidation may develop at the national level.

I would respectfully request, therefore, that the wording of the final bill concerning patients needing care in nursing homes be such that the California Commission for the Accreditation of Nursing Homes and Related Facilities

might qualify as the accrediting agency in this State until such time as a single broadly based accrediting body is operative nationally.

The commission was organized in March 1961 as a voluntary, nonprofit association. Its inception was prompted by the fact that the medical and dental professions, hospital administrators, and nursing home administrators felt the need for high standards of care to which nursing homes could subscribe. It is an effort to improve the care of the patient in nursing and convalescent homes.

The major purposes of the commission as stated in the constitution is as follows:

"To conduct a survey and accreditation program which will encourage the establishment and improvement of nursing homes and related facilities; and to establish and apply certain basic principles of organization and administration for efficient and kindly care of patients/guests of nursing homes and related facilities."

The membership of the commission consists of two representatives each from the California Medical Association, California Hospital Association, the California Association of Nursing Homes and one representative each from the California Dental Association and the Southern California State Dental Association. The commission is supported financially by contributions from the member organizations plus fees received from nursing homes and other related facilities requesting survey and accreditation.

As of March 31, 1965, a total of 252 requests for initial survey and accreditation had been received. Twenty-five nursing homes have been denied accreditation as not meeting the standards of the commission. Twenty-two have allowed their accreditation to lapse. In addition there are applications awaiting initial survey.

To qualify for survey by the Commission a facility must have been in operation under the same ownership for a period of at least 6 months. It is the feeling of the commission that this is the minimum period of operation which will permit a true evaluation of the quality of care in a facility.

Nursing and convalescent homes are furnished with full preliminary information of the standards of the commission and the requirements for accreditation. Inasmuch as the major objective is to improve the care of the patient and quality of care, the commission feels that its function is educational as well as accreditation. Facilities are furnished with self-evaluation questionnaires which permit them to find their weak spots and correct them before applying for accreditation.

Accreditation is purely voluntary on the part of the facility. Application accompanied by a fee of $60 plus $2.50 for each licensed bed must be made to the commission. A careful survey of the institution is then made. The report of survey is examined by all members of the commission and if approved a certificate of accreditation is issued to the facility. The licensing agency is then notified of the accreditation as is also Hospital Service of California, Hospital Service of Southern California, California Physicians' Service and interested commercial insurance companies which may write health insurance for care in convalescent hospitals.

Accreditation is for a period of 2 years from the date of survey and is not automatically renewed. For continuation of accreditation during the next 2-year period request must be made to the commission. A full survey is made and the report passed upon by all members of the commission as in the initial survey.

Provision is made in the bylaws whereby interim surveys may be conducted if there is a reasonable report or belief that the facility is not continuing to meet commission standards of accreditation. If this interim survey reveals major deficiencies or serious substandard operation, accreditation is withdrawn. The facility is then ineligible for accreditation for a period of 6 months and must file formal application for survey if they wish to become accredited. There is also provision for appeal and hearing before the commission.

In establishing criteria for nursing and convalescent homes which may be reimbursed for the care of individuals covered under health insurance, Hospital Service of California and Hospital Service of Southern California (Blue Cross) have indicated in their policies that facilities which have been accredited by the California Commission for the Accreditation of Nursing Homes shall be deemed to have met their criteria. Western-65, includes accreditation by this commission as a minimum requirement for a nursing or convalescent home to be qualified to receive payment under their policies. Other commercial companies writing insurance for nursing home care, accept accreditation as an indication that a facility meets their requirements for payments.

The nursing homes that are accredited or applying for accreditation are about equally divided between northern and southern California. They extend from Alturas on the north to Indio on the south. The great majority are in the areas adjacent to Los Angeles and San Francisco.

The first survey was conducted in September 1961. As of April 1, 1965, there were 196 nursing homes on the accredited list, representing 11,843 beds. This is 19 percent of the 1,025 licensed facilities in the State and 27 percent of the 43,227 beds.

The program of accreditation by the commission has been publicized widely to all nursing and convalescent homes in the State. As the program becomes better known, more and more nursing and convalescent homes are seeking accreditation. It is noted that physicians seeking a facility for convalescent care for a patient are giving preference to those facilities which have met the standards of this commission. The standards for accreditation are rigid but it is the feeling that such is necessary in order to promote a high quality of care in all of its aspects to the patients in nursing and convalescent homes that they may obtain the greatest benefits offered by medical and nursing science.

In all fairness to the more than 19 percent of facilities in California which have maintained high standards of care and in view of the unity of purpose of the member agencies supporting the commission it is respectfully requested that if an amendment requiring accreditation is introduced that the final wording of the amendment be such that the California Commission for the Accreditation of Nursing Homes and Related Facilities be allowed to qualify as the accrediting agency in this State until such time as a single broadly based accrediting body is operative nationally.

COUNCIL OF LOUISIANA BUSINESS AND TRADE ASSOCIATIONS,
Baton Rouge, La., May 1, 1965.

Re H.R. 6675, Social Security Amendments of 1965.

To the CHAIRMAN, HON. HARRY F. BYRD, AND MEMBERS OF THE SENATE FINANCE COMMITTEE,
U.S. Senate,
Washington 25, D.C.

GENTLEMEN: Without a public hearing before the House Ways and Means Committee, H.R. 6675 passed the House of Representatives on April 8, 1965, and is now under your consideration. According to press notices only those employer representatives who have previously arranged for appearances will be heard by your committee.

Respectfully submitted, however, is the position of Louisiana Business, coordinated and endorsed by the business and trade associations named herein, regarding H.R. 6675, Social Security Amendments of 1965. It is urged that a copy of such position be made available to each member of the committee and to the Congress of the United States.

POSITION OF LOUISIANA BUSINESS ON H.R. 6675

Only the vaguest idea of the enormous scope of this bill, designed within the House Ways and Means Committee in executive sessions and with no public hearings, has been made known to the American public. As an example of this, on national television and in the national press, this 298 page document has been called very simply the medicare bill. Such news media have quoted the administration as stating immediately after its passage by the House: "Thirty years from now you will realize the benefit of the historical passage of this medicare bill."

Yet, the report of the Committee On Ways and Means to Congress gives the overall purpose in these categories.

(1) To provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act, etc.;

(2) To expand the services for maternal and child health, crippled children, and the mentally retarded, and to establish a 5-year program of special project grants to provide comprehensive health care for needy children of school age or preschool age;

(3) To revise and improve the benefit and coverage provisions and the financing structure of the Federal old-age, survivors, and disability insurance system, etc.

Obviously, it would be quite difficult for the American public to have the slightest idea of the enormity of this bill even after reading the 264 page committee report on the 298 page bill.

Nevertheless, Louisiana Business believes that in all fairness to the American people, at least the following highlights of the scope of this legislation should be emphasized nationwide.

SYNOPSIS OF SCOPE

I. *Health insurance and medical care for the needy*

A. A basic plan providing protection against the costs of hospital care financed through a new and separate payroll tax and a new and separate trust fund.

The new tax.—This new tax begins at 0.7 percent of payroll and increases to 1.6 percent of payroll, divided equally between worker and employer. The tax base is increased from $4,800 per annum to $6,600 per annum. The $200-per-month worker and his employer each will pay $38.40 per year and the $550-per-month worker and his employer will be taxed $105.60 per year. Yet, the benefits will be exactly and basically the same for each worker as in the medicare proposals of former years.

Unless a hospital agrees to follow all of the regulations and price tags placed on it by the Federal regulator, it will not be licensed as a provider, and these services would not be available there under that plan. There are, of course, a number of regulatory measures aside from this bill which the Federal Government could invoke to force institutions to become providers.

The cost.—This is, of course, a reestimate of the popular slogan, "For less than 3 cents a day, etc." The tax in this bill for some workers and their employers is 29 cents per day, which is about 10 times the original slogan used to popularize prior medical plans. A worker and his employer together will pay $105.60 per annum toward hospitalization cost of those 65 and over.

According to the Federal Department of Health, Education, and Welfare (p. 252 of the report of the Committee on Ways and Means to Congress) the cost of providing hospital benefits to those now 50 years of age or over is $140 billion. Those 50 years of age or older will contribute not more than $7 billion for their benefits.

Accordingly, the Federal Department of Health, Education, and Welfare concludes that—

> The cost that younger workers will be required to pay to provide benefits to those now 50 years of age or over is $133 billion (p. 252).
>
> The committee report further states (p. 251), "The actual cost of the hospitalization program per workers entering the work force at age 21, with interest at 3½ percent per annum, will amount to $8,590."

That worker, meanwhile, during all of his working years, has the responsibility of self-insuring the health needs of his family and himself out of his own earnings.

B. The second portion of the coordinated approach for health insurance under H.R. 6675, has to do with a voluntary supplementary plan providing payments for physicians and other medical and health services financed through small monthly premiums by individual participants and matched equally by the Federal Government out of general revenues.

Premiums.—Participant would put up $3 per month and Government would put up $3 per month out of general revenues. These funds would be placed in a government trust fund, from which the insurance companies would be paid. Here, again, the Federal Secretary would determine which insurance companies could participate and be permitted to enter into a Federal Government contract.

Benefits.—There would be a $50 annual deductible. Then the plan would cover 80 percent of the patient's bill for physician and surgeon services; home health services, diagnostic X-ray, laboratory, electrocardiograms, and other tests; ambulance service, surgical dressings, splints, cast, iron lungs, oxygen, wheelchairs, artificial limbs, etc.

The $3 per month premium of the individual would be deducted from current social security benefit, if any. The committee report (p. 6) specifically notes that since social security benefits are at the same time being increased by at least $4 per month, such increase would more than pay for this premium.

COMMENTS ON MEDICARE PORTION OF H.R. 6675

Each member of the Senate Finance Committee was furnished on November 25, 1963, the position of Louisiana Business on medical care for older citizens.

Louisiana Business urged then and continues to emphasize that if the Congress of the United States determines that senior citizens must be medically insured, the necessary funds should be made available on some test basis out of general revenue to pay the premiums actuarially established by private insurance carriers, if the individual desired to participate and is willing to contribute a part of that premium.

To some extent, but regulated, that principle was recognized by the House of Representatives in voting upon the supplementary insurance portion of H.R. 6675. If this principle is sound, at all, it should be just as sound for insuring hospitalization costs.

Louisiana Business holds that if persons 65 years of age or over do not have hospital, doctor, nursing, and medical coverage, but want it and cannot pay for it solely out of current income, then the matching principle established in this bill should be extended to hospitalization coverage as well and furnished by established, sound, nationwide plans now on the market.

Some of these plans are selling for slightly more than $100 per year including catastrophic health insurance. Under a matching arrangement, the individual would put up $50 or less per annum and Government would put up $50 or more per annum (H.R. 6675 proposes $36 per annum solely for doctors' and some related services). Certainly, hospitalization insurance alone on a mass basis would not cost $105.60 per annum, which this bill proposes the worker and his employer put up for insurance for others.

There would then be absolutely no need for Government regulated medicare (now called hospital insurance) under social security. Furthermore, the cost would be considerably less. Of paramount importance, the individual would retain his freedom of choice and maintain his dignity in paying at least part of the premium.

II. INCREASED ASSISTANCE TO STATES FOR VARIOUS SERVICES FOR HEALTH CARE

The position of Louisiana Business has always been and continues to be that if help is needed in this area, each State is qualified to determine what and how much is needed. Accordingly, Louisiana Business is in full agreement with this portion of H.R. 6675.

III. INCREASE IN FEDERAL OLD-AGE, SURVIVORS' AND DISABILITY BENEFITS AND THEIR FINANCING.

This portion of H.R. 6675 relates to: (*a*) Benefit increases and (*b*) Financing such increases.

The position of Louisiana Business is that inflation has made an increase of 7 percent across the board in monthly benefits an absolute necessity. However, it holds that financing of such increases should not be borne almost entirely by considerably less than half of the Nation's workers and their employers.

A. Increased social security benefits including those for survivors and the disabled

The bill provides—

(1) A 7-percent across-the-board benefit increase to 20 million present recipients. The new monthly minimum would be $44 (now $40) and the new monthly maximum for those now drawing would be $135.90 (now $127). In the future the maximum could go to $149.90 per month in about 5 years and then to $167.00 per month in another 5 years.

(2) Family maximum benefits, now $254 per month, would be increased to $286.80. By 1971 such family benefit could be $312 and 5 years later $368 per month.

(3) Presently, a child's benefit ceases at age 18. The bill extends this to age 22 if the child is a full-time student after age 18.

(4) Presently, widows are ineligible until age 62. The bill permits an actuarially discounted benefit at age 60.

Louisiana Business is in accord with the foregoing increases occasioned principally by inflation.

However, Louisiana Business has deep concern and very serious objections with regard to the following change proposed in H.R. 6675:

(5) Amendment to present disability requirement.

The bill eliminates the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration. It provides instead that a worker would be eligible for a disability benefit if he

has been totally disabled (even temporarily), through a continuous period of at least 6 calendar months. Moreover, such benefits would be payable after a waiting period of 5 months rather than the present waiting period of 6 months.

It proposes that disabled workers will be eligible for Federal social security benefits during the same period of time that they are receiving workmen's compensation and other benefits under State laws. Recipients would then be eligible for two or several benefits for the same disability period.

This measure might be intended to place the responsibility on the Federal Government for compensating workers for job-connected injuries and thereby make it unnecessary for States to have workmen's compensation statutes. Meanwhile, however, when disabled workers are able to secure more income when disabled than when working, there would be little if any incentive for them to seek rehabilitation or again become self-supporting.

Louisiana Business, therefore, not only because of the added cost but also for the general good of the social security program is firmly opposed to this change in benefit.

(6) Miscellaneous other liberalizations in benefit entitlement appear to be in the nature of correcting some comparative injustices and Louisiana Business believes these are principally for the general good.

B. Financing the benefit increases

More than in any other prior financing of increased benefits this bill grossly discriminates against better paid workers and their employers in forcing them to finance the entire increased costs. Those already receiving benefits will, of course, pay nothing for the large increase. However, the majority of present workers who will accrue considerably increased benefits, as outlined in the foregoing, will receive such increased benefits with a decrease in tax. The entire cost then will be borne by workers earning more than $400 per month and the businesses which pay them their wages. Under present law and present benefit schedule the tax rates are as follows:

Years 1966 and 1967	4.125 percent on 1st $4,800 per annum
Year 1968 and thereafter	4.625 percent on 1st $4,800 per annum

H.R. 6675 proposes the following (exclusive of the medicare separate tax):

Years 1966 through 1968	4.0 percent on 1st $5,600 per annum
Years 1969 and 1970	4.4 percent on 1st $5,600 per annum
Years 1971 and 1972	4.4 percent on 1st $6,600 per annum
Year 1973 and thereafter	4.8 percent on 1st $6,600 per annum

The Social Security Bulletin of February 1965 (page 23) states that the average total earnings per worker subject to social security tax was $3,970 for the year 1963. (From figures given in the March 1965 issue, apparently this increased about 2.4 percent for 1964.) From the foregoing, it is observed that a substantial increase in benefits accrues to all workers.

Nevertheless, the proposed financing actually results in decreases for the next 7 years in presently scheduled tax of those earning less than $4,800. For 1966 and 1967 the $400-per-month worker will pay $6 per year less than scheduled in present law; in 1968 he will pay $30 less than scheduled and for the years 1969 through 1972 he will pay $10.80 less per year than under present law. In spite of considerably increased benefits he will pay $85.20 less in payroll social security tax during the next 7 years.

Quite obviously, then, the entire cost of the benefit increase for the 20 million now on the benefit roll as well as the accrued benefit increases of the majority of workers will be financed solely by those earning more than $400 per month and the businesses which pay them.

The tax for the $550-per-month worker is increased from a maximum of $222 per year under present law to $816.80 per year (exclusive of the additional tax proposed for medicare). The employer pays an additional equivalent amount. Exclusive of the separate medicare tax proposed by H.R. 6675, the social security tax per annum for the $550-per-month man would be $633.60 or $52.80 per month, of which $26.40 per month will come out of the worker's paycheck.

It appears impossible to justify this discrimination. In its report to Congress the Committee on Ways and Means apparently attempts to do so by a number of assumptions. Among these are the following:

"Your committee was advised by the Department of Health, Education, and Welfare that, in the future, earnings are estimated to increase at a rate of about 3 percent per year." (Page 50.)

Table given on page 53 of the report, assumes that today's average daily wage of $20 will increase to $43.82 in 20 years and to $142.13 in 50 years.

"Accordingly, although your committee believes that, under the likely condition of rising wages over the next 25 years, the earnings base will be adjusted upward beyond the $6,600 in 1971, the conservative assumption should be made for the purpose of the actuarial cost estimates that no further increases will occur after 1971." (Page 56.)

Louisiana Business urges the committee to avoid this discrimination. If every worker is to accrue increased benefits to the extent of approximately 7 percent, in equity each worker's tax should be correspondingly increased. In essence that principle was recommended to the House Ways and Means Committee by the Federal Advisory Council on Social Security before the introduction of H.R. 6675 (pp. 7 and 38, Social Security Bulletin, March 1965).

SUMMARY AND CONCLUSIONS

Combined social security and medicare tax imposed by H.R. 6675 totals as much as $739.20 per year for a worker (11.2 percent of $6,600). Of this amount $369.60, or $30.80 per month will be deducted from the worker's paycheck. There is no doubt that under a normal working career, the combined employer-employee tax invested in private pension and health insurance would provide the worker far more benefits than contained in this proposal.

Louisiana Business, in view of the many assumptions made in the report to Congress by the Committee on Ways and Means, must conclude that the tax demanded from business and the worker will inevitably be increased along with benefits.

Louisiana Business holds that if the Congress feels that there must be compulsory medical coverage of all senior citizens, the free choice of any of the sound plans offered on the competitive market should ' ' theirs. Standard comprehensive medical coverage policies should be made available to anyone age 65 or over. The individual would pay a portion of the premium and the Government, out of general revenues, would pay the rest on an established scale according to the individual's total income.

Otherwise, there is no possibility of avoiding Federal regulation and control of the individual and the services rendered, with the attendant high noncompetitive political cost and necessitating a disproportionate expropriation of more and more wages of the worker and the earnings of his employer.

Moreover, it will be politically impossible to resist the inevitable demand of the worker, who pays part of the bill, to extend the same coverage to him while working with unlimited cost.

With the exception of the disability entitlement amendment, Louisiana Business is generally in accord with the benefit increases proposed in the OASDI program and the liberalization of Federal grants to broaden State plans.

However, Louisiana Business urges the committee and the Congress to change the method of financing increased benefits and follow essentially the equitable principle of an across-the-board tax increase for an across-the-board benefit increase.

Certainly, the alarming progression in Government concept, embodied in H.R. 6675, of taking more and more from some to give to others, once enacted can hardly be changed in the future.

Louisiana Business, therefore, is of the firm conviction that such principle would be greatly accelerated during the next 30 years with irreparable damage to many industries, the free enterprise system and to its millions of workers.

Coordinated, endorsed and respectfully submitted by:

Automotive Wholesalers Association of Louisiana.
Chamber of Commerce of the New Orleans area.
Construction Industry Association of New Orleans.
Deep South Farm and Power Equipment Association.
Louisiana Automobile Dealers Association.
Louisiana Building Material Dealers Association.
Louisiana Dairy Products Association.
Louisiana Highway & Heavy Construction Branch, Associated General Contractors of America.
Louisiana Laundry and Cleaners Association.
Louisiana Manufacturers Association.
Louisiana Motor Transport Association.
Louisiana Oil Marketers Association.

Louisiana Restaurant Association.
Louisiana Retailers Association.
Louisiana State Chamber of Commerce.
Louisiana Wholesale Grocers Association.
Louisiana Wine & Spirits Foundation.
Printers and Stationers Association of Louisiana.
Shreveport Wholesale Credit Men's Association.
Southern Pine Industry Committee.

I hereby certify that the position of Louisiana Business, as outlined in the foregoing, has been endorsed by the above named associations.

L. L. WALTERS, *coordinator.*

STATEMENT ON MEDICARE, H.R. 6675, SENATE FINANCE COMMITTEE, APRIL 29, 1965, BY E. S. HALL, SECRETARY, FREEDOM, INC., FARMINGTON, CONN.

I am E. S. Hall, a Connecticut yankee in Washington. Having arrived at "threescore years and ten", I represent the 20 million aging citizens who you imagine might vote for you if you support this medicare bill: "Social Security Amendments of 1965"—health insurance for the aged and medical assistance—entitlement to hospital insurance benefits—conditions to be met, deductibles, exceptions, limitations, scope, and payment of benefits, duration and procedure for payment of claims of providers of services; amounts and payment of premiums and contributions (flat-rate income taxes): trust funds to be invested in Government bonds; hospital inpatient, extended care, outpatient, arrangements, establishments, enrollment periods, coverage period, determinations, appeals, eligibility, exclusions from coverage, etc., etc., 296 pages to be added to the more than 2,000-page Internal Revenue Code of 1954 as amended to date. It is obvious that, before the bureaucrats (or the Philadelphia lawyers we cannot afford to hire) can tell us how much of our hospital and other medical bills will be paid, we shall have either recovered or died. If you support this monstrous and complicated medicare bill, will we vote for you? Not on your life.

However, the 20 million aging citizens that I represent will gladly vote for you if you will throw this 296-page medicare bill into the ashcan and enact the 22-page freedom tax bill, a bill to give every taxpayer a take-home raise in an economic climate that will enable most of us to care for ourselves all the days of our lives, and let the needy change from the welfare laws to an overall system of cash aid for food, clothing, and shelter, plus payment of all their medical bills, locally administered by social workers and the clergy. No premiums. No contributions. No medicare-security payroll taxes. No accounting overhead. Lowest cost to income taxpayers. Free market medical care for all the needy without regard to age, race, creed, color, or previous condition of serfdom or freedom. Complete medicare with total security. If you really want the votes of the millions I represent, give us the freedom tax law now.

MAY 4, 1965.

H.R. 6675
Hon. HARRY F. BYRD,
Chairman, Senate Committee on Finance,
New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The 98th Annual Session of the National Grange, which was held in Atlantic City, N.J., in November of 1964, reaffirmed previous positions of the National Grange in opposition to medical care and aid for elderly citizens financed out of, or through, social security. They specifically referred to the position of the National Grange in 1963, which is as follows:

"In 1960 the National Grange adopted a resolution to the effect that 'the freedom of the individual to choose the health and medical services desired' should be maintained. With this in mind, this committee reaffirms its position and opposes the enactment of the King-Anderson bill or any similar legislation which would increase social security taxes to finance medicare. The Grange reaffirms its support of the Kerr-Mills plan, in opposition to compulsory aid, through social security. The committee commends private insurance companies for their efforts in providing plans for hospitalization and health insurance for senior citizens."

Will you be so kind, sir, to convey to your distinguished committee this position of the National Grange.

Respectfully,

HARRY L. GRAHAM, *Legislative Representative.*

STATEMENT OF EDWARD W. KUHN, PRESIDENT ELECT, AMERICAN BAR ASSOCIATION, ON BEHALF OF THE AMERICAN BAR ASSOCIATION

(In opposition to section 303(a) (1) and (2) of H.R. 6675 (89th Cong., 1st sess.) which would change the definition of disability under the social security program to allow disability payments for short-term, temporary disability, thereby duplicating the payments of State workmen's compensation laws)

The American Bar Association is opposed to the inclusion in H.R. 6675 of section 303(a) (1) and (2).

This section would amend the present definition of disability under the social security law to strike the requirement that, in order for an individual to be eligible for social security disability benefits, his disability must be of long continued and indefinite duration or be expected to result in death.

Since 1958, disability benefits paid under social security have duplicated payments from State workmen's compensation programs in the area of permanent and total disability. The effect of the proposed change in H.R. 6675 would be to expand the duplication of social security beyond the permanent total area into the area of short-term, temporary disability.

If this proposal is enacted, it will represent a broad change in the apparent philosophy underlying the adoption of the social security disability provision. The basis of justification for including disability payments under social security was that an individual who suffered a disability of long continued duration or one which was likely to result in death was totally and permanently removed from the work force and thus, in effect, undergoing an early retirement. This fitted in well with the philosophy of the old age and survivors insurance program which provided benefits for those persons or dependents who were removed from the work force as a result of retirement or death.

If the disability amendments contained in the aforementioned subsections of sections 303 are enacted, they will represent a major change in this philosophy. The individuals who will be included as eligible for disability will not necessarily have been completely and permanently removed from the work force. A substantial number of individuals eligible for such benefits will be suffering only short-term disability, and there is every reason to believe that they will be returned to the work force within a limited period of time.

The American Bar Association feels strongly that no such broad change in the basic philosophy of the social security disability provision should be undertaken without considerable study both as to the necessity for such change and its long-term effect.

This proposed change in the definition of disability will also result in a substantial broadening of the duplication of workmen's compensation payments by social security. If this is allowed to go into effect, it will not only discourage the work being done in rehabilitating injured workers, but will also reduce the incentive for employers to make strong safety efforts.

Duplication of workmen's compensation benefits and social security disability payments have in many cases seriously hampered efforts to rehabilitate injured employees and return them to their jobs. It would be most unfortunate if the concept of rehabilitation, which has become generally accepted as one of the major objectives of workmen's compensation, should receive a serious setback because of broadened duplication. Furthermore, the State workmen's compensation programs have been a major factor in the reduction of accidents over the years. One of the original purposes of the enactment of workmen's compensation laws in the various States was to produce the needed incentives for good safety management. The cost of work injuries is, through the rating system, borne directly by the employer under whose supervision injuries have occurred. As a result, the number of work-connected injuries and fatalities in private industry has been greatly diminished. This reduction of work-connected injuries and fatalities in private industry has been greatly diminished. This

reduction of work-connected injuries in private industry was recently noted by President Johnson in a statement to all Federal departments and agencies requesting them to develop programs within their departments and agencies which would produce results similar to those being obtained in private industry.

However, we feel that the most serious effect of this proposed change will be that it will constitute a major step toward the substitution of social security for workmen's compensation system. It is obvious that two systems of compensation for work-connected disability which duplicate each other will not be tolerated for a long period of time. As the area of compensation under social security is broadened, there will be great pressure for reduction in the areas covered by State programs. As this pressure mounts, it can only result in gradual elimination of the State workmen's compensation programs which has successfully protected injured workers for over 50 years.

The Committee on Ways and Means of the House of Representatives of the U.S. Congress recognized the serious problem of duplication, and in its report on H.R. 6675 recommended that the Department of Health, Education, and Welfare conduct a study of the problem and report back to the committee next year. The American Bar Association strongly feels that no change in the definition of disability should be undertaken until ample opportunity has been had to fully consider the necessity for changing the definition and to fully explore the possible effect upon State workmen's compensation programs.

If the definition is expanded before this is done, the duplication problem will be substantially increased, and could result in a severe blow from which the State workmen's compensation system may never recover.

In February of 1963, the house of delegates of the American Bar Association adopted a resolution concerning duplication and overlapping of provisions of the social security law and the several States' workmen's compensation acts. As a matter of policy the association expressed its opposition to any further legislation which would discourage the States from improving their own system or would infringe on the rights of the States to enact and administer their own system of workmen's compensation benefits.

The American Bar Association feels that the proposed change in the definition of disability is set forth in section 303(a) (1) and (2) in H.R. 6675 would constitute such legislation resulting in irreparable harm to the State workmen's compensation programs.

We strongly urge the aforementioned sections be deleted from the bill.

PORTLAND, MAINE, *May 4, 1965.*

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: At the last meeting of the Maine Societies of Pathologists the membership instructed me to communicate our objection to Senator Paul Douglas' amendment to H.R. 6675.

It is our considered opinion as practicing pathologists that such legislation would result in a complete loss of control of the quality of laboratory medicine by the physicians responsible. It is our opinion that the control of laboratory medicine exerted by many hospitals has resulted in an appreciable lag between scientific research and its applications to clinical medicine.

This society feels that the failure to utilize new knowledge will be increased by governmental controls of laboratories medicine. The Maine pathologists object to a professional-technical split of fees, as outlined in H.R. 6675. In our opinion such legislation would tend to restrict pathologists in selecting and training technical personnel, purchasing equipment of their choice, instituting the methodology they consider best for a given procedure, and operating an adequate quality control program. We respectfully urge your committee to eliminate from the medicare bill H.R. 6675 all physicians' services, fully realizing that this may not be possible. If not possible this society requests the committee to recommend to the Senate passage of H.R. 6675 in its original form.

Dr. GERALD C. LEARY,
Secretary, Maine Society of Pathology.

THE IOWA HOSPITAL ASSOCIATION, INC.,
DES MOINES, IOWA, *May 3, 1965.*

HON. HARRY FLOOD BYRD,
Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: At the annual meeting of the House of Delegates of the Iowa Hospital Association held in Des Moines, Iowa, April 27, 28, and 29, 1965, the delegates heard a presentation of the Federal legislation (H.R. 6675) passed by the House of Representatives and now before the Senate Finance Committee.

The hospitals of Iowa are deeply concerned about that portion of H.R. 6675 which seeks to distinguish payment to hospitals for the services of pathologists, radiologists, anesthesiologists, and physiatrists, from the remaining costs of operating the departments which these physician specialists supervise.

During the course of a 5-year controversy between these physician specialists and hospitals in Iowa between 1954 and 1960, the practicality and other merits of this "professional-technical split" were thoroughly considered. Both sides to the controversy rejected this proposal as unsound, impractical, and potentially harmful to the quality of these services in hospitals. The reasons are as follows:

1. These four specialties of medicine always have been and must continue to be monopolies. Since the pathologist, for example, is the administrative head of a major department of the hospital, it is possible to appoint only one person for this responsibility. Employees cannot have three, four or more separate supervisors.

2. There is a severe shortage of these medical specialists and only in the very large cities of the United States would it be possible to have competition between these specialists, no matter how the charges for their services reached the patient. In the entire State of Iowa, less than 50 percent of the 173 hospitals have the services of these specialists. All other hospitals must depend upon a general practice physician for supervision of these departments.

3. The monopoly situation thus arises both from the hospital's need for one administrative head of the department, and from the scarcity of these specialists in the United States. Monopoly situations must be controlled. If these physicians are not under contract with hospitals, they will be tempted to take advantage of their preferential position in the form of higher charges for services rendered as compared with those charges now made under contract control.

4. Separate billings by these monopoly specialists will result in multiple billings to each patient instead of one charge rendered via the hospital as at present. For the four departments concerned, this will mean one charge from each of four specialists, plus one from the hospital, making a total of five bills instead of all being included in one hospital bill. Patients will be overwhelmed with bills from physicians they neither select nor recognize, and seldom even see.

5. The direct billing by the specialist to the patient will encourage nonspecialist physicians to administer anesthesia, to interpret X-rays, and even to examine laboratory tissues, blood smears, and cultures. No physician wishes his patient to receive multiple bills from several other physicians, and to avoid it, the nonspecialist will tend to provide these services himself. This will tend to lower the quality from the high level now common to American hospitals.

Because of these considerations, the House of Delegates of the Iowa Hospital Association urges the amendment of H.R. 6675 to provide for payment of these four monopoly specialist physicians from the basic hospital benefits of the program.

Sincerely yours,

ROLAND B. ENOS, *President.*

TESTIMONY PRESENTED BY DR. MACKLYN LINDSTROM, CHAIRMAN, COMMITTEE ON SOCIAL WELFARE, DIVISION OF ALCOHOL PROBLEMS AND GENERAL WELFARE, GENERAL BOARD OF CHRISTIAN SOCIAL CONCERNS, THE METHODIST CHURCH

Mr. Chairman, we have requested this opportunity to present written testimony before the Senate Finance Committee on H.R. 6675 because the General Conference of the Methodist Church for the first time adopted policy statements related to medical care and public welfare at its quadrennial meeting in April of 1964.

We do not pretend to be experts in these highly technical and complex fields. As we understand H.R. 6675, we feel that it is quite compatible in intent with the policy statements adopted by our church.

The Methodist General Conference stated: "We stand for the provision of adequate medical care for all people, with special attention being given the aging, the young, minority ,and low-income groups." It went on to affirm, "Our national resources should be mobilized to furnish health services to those in need. The principle and use of prepayment health insurance is good. Subsidies and administrative coordination by private, Federal, and State governmental agencies may be necessary to care for unmet needs."

We see in the health insurance for the aged section of H.R. 6675 an attempt to meet existing need with minimum of hardship on persons and a maximum of respect for the dignity of the individual. The social security provision enables every person to "earn" his right to basic hospital and nursing home care upon reaching age 65. The voluntary supplementary plan providing payments for physicians and other medical and health services allows for individual participation, yet allowing Federal matching in order to more evenly distribute the cost on the basis of ability to pay, and taking care of needs that would be too costly if included in the social security program. We are not certain these programs will meet all the existing needs, but we feel this is a giant step.

In the expansion of the Medical Assistance for the Aging Act (Kerr-Mills) we see a real attempt not only to more adequately meet the needs of medically indigent aged, but also to provide for the medically indigent child and his family, as well as the blind and permanently and totally disabled. This is a welcome addition as are the child health program amendments.

The revision of the OASDI program will make it possible for more persons to live with dignity. Incomes under these programs will still be quite low, particularly for some, but improved. These provisions move in the direction of providing a more adequate base for persons to live as free human beings. We have recently become aware of the hardship created for a small number of older women who have been divorced and cut off thereby from the social security benefits accumulated by their former husbands. We feel that the provision for wife's and widow's benefits for divorced women is fair, although a little investigation indicates that the lowering of the number of years of marriage required for this benefit to 10 years (instead of 20 years) would add little additional cost to the program and would more adequately meet this need.

In testimony presented to the Advisory Council on Public Welfare on April 30, 1965, we were pleased to quote our new general conference statement on public welfare which says, "We believe that meeting human need is both a private and a community responsibility. Adequate public assistance should be made available to all persons solely on the basis of need. Every individual should provide for his own needs and share responsibility for the needs of others to the full extent of his ability, but we believe that no person in an affluent society should be demoralized because of unmet need."

We find in the public assistance amendments of H.R. 6675 provisions which move toward this objective as stated in our church policy. The greatly needed increase in the Federal share of assistance grants is to be passed on to the recipient. The inclusion of tubercular and mental patients in the old-age assistance and medical assistance for the aged programs will benefit many. So will the increase in earnings exemption. The Congress can give a big boost to many who are at the bottom of the economic heap through these public assistance amendments. It will provide an important step toward meeting human need.

We believe that the recent action by the General Conference of the Methodist Church is an indication of growing public support for more adequate public programs in health and welfare and are grateful that the Congress of the United States is developing such programs.

International Association of Fire Fighters

Submitted by William D. Bucke, President

The International Association of Fire Fighters strongly supports the social security system. However, the simple truth of the matter is that social security cannot be extended to fire fighters and policemen, who are covered by a State or local retirement system, without in turn weakening or damaging such systems. For this reason, we are unalterably opposed to any effort which may be made to eliminate or repeal the clause (sec. 218(d)(5)(A)) which excludes fire fighters and policemen, who are under a retirement system, from coverage under the Social Security Act.

As the committee will recall, last year section 11 of the House bill on social security revisions attempted to repeal this exclusion clause. Fortunately, however, your committee and the Senate in its wisdom adopted the Ribicoff amendment striking said section 11 from the House bill. The committee on conference agreed at that time that the exclusion clause should be continued.

This year we are satisfied with the House bill (H.R. 6675) to the extent that it leaves the exclusion clause intact. We are not aware of any effort which is being made on the Senate side to tamper with this much needed exclusion.

This, notwithstanding, since this matter was an issue in the last session of Congress, we would like to take this opportunity to set forth the following as the reasons why the firemen's and policemen's exclusion clause should remain unchanged:

(1) The referendum section of the Social Security Act does not contain adequate provisions which will assure fire fighters and policemen that they will not be forced under social security against their will. To the contrary, section 218(d)(6)(C) permits certain States to divide the retirement system so that even if all the department members but one are opposed to social security coverage, that single member can vote for it and thus force all department members thereafter to come under the social security system against their will. (See supporting statement No. 1.)

(2) The nature of the duties of fire fighters and policemen is such that it requires retirement at a far earlier age than that provided for under social security. (See supporting statement No. 2.)

(3) Elimination of the exclusion clause would damage the ability of fire fighters and policemen to protect early retirement provisions in those communities where such provisions now exist. Further, it would serve as a bar against improving those retirement systems which do not measure up to the retirement standards required in the firefighting and police service. The inclusion of members of fire and police departments under social security in the States of Kansas and South Dakota has already started a movement backward toward the later retirement requirements provided for under social security as opposed to the earlier retirement requirements necessary to meet the needs of fire fighters and policemen. (See supporting statement No. 3.)

(4a) Certain municipal administrators plan to use social security as a device through which retirement benefits of firefighters and policemen, provided for under State and local systems, will be reduced. Since these systems are, of necessity, more liberal than social security and therefore more expensive to the municipal employer, they hope to reduce the municipality's share of pension costs by substituting social security in lieu of these systems. (See supporting statement No. 4a.)

(4b) The policy declaration of Congress which states that there shall be no impairment of benefits of State and municipal employees, is certainly well intentioned. Unfortunately, it carries no legal weight or influence with those municipal administrators who view social security as a means of escaping from their pension or retirement system obligations. (See supporting statement 4b.)

(5) The effect on fire and police department pension systems by the intrusion of social security cannot be judged on the same basis as social security's impact on the retirement systems of other State and municipal employees. As previously stated fire and police department pension systems are, because of necessity, more liberal and therefore more expensive than the systems covering most other employees. In addition, because they were started before retirement systems were funded, fire and police department plans usually operate on a pay-as-you-go basis with the unfunded liabilities mounting every year. All of this causes municipal administrators to consider fire and police department retirement systems in a far different light than the systems covering other State and municipal employees. (See supporting statement No. 5.)

SUPPORTING STATEMENT NO. 1—FIREFIGHTERS AND POLICEMEN FORCED UNDER SOCIAL SECURITY

Except for the exclusion clause, firefighters and policemen enjoy no protection under the Federal law against being forced under social security against their will. Section 218(d)(6)(C) permits 17 States to divide their retirement system so that a single department member can compel every future member of his department to come under social security. It is now being recommended by the

Advisory Council that this authority to divide the retirement system be extended to the remaining 33 States.

If the exclusion clause is eliminated, and the authority to divide the retirement system is extended to all of the 50 States, social security will be forced on every fire and police department in the Nation, even though the overwhelming majority of department members are opposed to it.

One might question, "What is wrong with a system which forces new members under social security so long as the current members are protected?"

The answer is that pension benefits are part of the total wage package, the greater the benefits, the higher the wages. Thus, if you have two different levels of pension benefits, you have two different levels of wages. In effect, the new firefighter or policeman covered under social security would be working for less wages than his counterpart who was covered by the State or local retirement system.

This disparity in benefits or wages would surely destroy the morale of any department. You just cannot have two employees performing the same duties and exposed to the same hazards, yet pay one of them more than the other.

The only practical solution to the problem is to strengthen the caluse in the Federal law which excludes firefighters and policemen from social security coverage.

SUPPORTING STATEMENT NO. 2—WHY EARLY RETIREMENT FOR FIREFIGHTERS AND POLICEMEN?

The nature of the duties of firefighters and policemen demands that they have great physical strength, ability, coordination, stamina, and endurance. Most men begin to lose a good part of these characteristics after they reach age 50, thus reducing their effectiveness in their job. Early retirement for those employees is necessary in order to maintain efficiency in the firefighting and police services.

By the same token, the rigors of firefighting or police work have an increasingly damaging impact on the health of department members with each succeeding year after age 45. Medical science has established that advancing age and the work of firefighters frequently is the reason why such men suffer from heart disease. In order to afford reasonable protection to the health of the men engaged in these hazardous occupations, firefighters and policemen must be permitted to retire at an early age.

One of the biggest difficulties of fire and police departments today is the recruitment of qualified men at the salaries the municipalities can afford to pay. An important inducement is a sound retirement program. If there is danger of this program being weakened this attraction will be lost and consequently the difficulty of recruiting satisfactory personnel will be greatly increased.

SUPPORTING STATEMENT NO. 3—THE EXTENSION OF SOCIAL SECURITY DAMAGES, FIRE AND POLICE DEPARTMENT RETIREMENT SYSTEMS

The intrusion of social security on fire and police department retirement systems in certain States which have been exempted from the exclusion clause, has had a damaging effect on the retirement systems of those States.

In Kansas and South Dakota, social security has lent support to those who would unduly increase the length of service and age requirements for firefighters and policemen in those States.

In many other such States, where the age and length of service requirements were too high to begin with, social security has served as a deterrent against reducing these requirements.

The overall impact of social security on these States is to cause a shift from the retirement standards essential in an effective firefighting or police force to the more general standards of social security.

It would be in the best interest of every community if conditions were restored to where they were in 1956 when every firefighter and policeman in the Nation, who was covered by a retirement system, was excluded from social security.

SUPPORTING STATEMENT NO. 4A—MUNICIPALITIES TO USE SOCIAL SECURITY IN PLACE OF FIRE AND POLICE RETIREMENT SYSTEMS

Many of our local unions have been challenged by efforts of municipal administrators to integrate social security with the existing retirement system for

present fire department members and to substitute social security for the retirement system of new members. Most of these administrators have been frank to say that they view this as a means of escaping from pension obligations which they claim are costly.

The only thing which has thwarted them is the presence of the exclusion clause.

If the exclusion clause were removed, our unions would be powerless to defend themselves against this maneuver which at best would create a double standard of benefits for employees who perform the same duties and who are exposed to the same hazards.

There is no justification for having the Federal Government give municipal administrators the tools through which they might escape their obligation to employees who have so faithfully served their communities. For this reason, the exclusion clause should be strengthened rather than weakened or eliminated.

SUPPORTING STATEMENT NO. 4B—DECLARATION OF CONGRESS

It has clearly been the purpose of Congress that the extension of social security to State and municipal employees shall not result in the impairment of State or local retirement systems. Unfortunately, this congressional declaration has no legal weight or effect on those administrators who are subject to the pressure inherent in most municipal budgets. This declaration is all the more meaningless in the case of firefighters and policemen because their retirement systems are far more costly than those of other State and municipal employees.

The only practical way that Congress can protect fire and police department retirement systems from impairment caused by social security is to strengthen the exclusion clause so that social security cannot be extended to firefighters or policemen who are covered by such systems.

SUPPORTING STATEMENT NO. 5—RETIREMENT PROBLEMS OF FIREFIGHTERS AND POLICEMEN DIFFERENT THAN THAT OF OTHER STATE AND MUNICIPAL EMPLOYEES

Retirement systems were adopted for firefighters and policemen long before they were established for other State and municipal employees. They were developed on a pay as you go basis because funding pension systems was not an accepted practice in those days. As a result, the cost of such plans continues to mount with each passing year.

In addition, the retirement requirement of firefighters and policemen are of necessity much more liberal than that of other State and muincipal employees. This again means that the fire and police department plans impose a much greater cost on the municipal employer than does the system of other public employees.

Since there is such a significant difference in costs between these two types of retirement systems, the experience of other State and municipal employees to whom social security has been extended, does not serve as a useful basis upon which to judge what would happen if social security were extended to firefighters and policemen.

Therefore the problem of the firefighters and policemen must be evaluated on the basis of the demonstrated attitude of municipal administrators and on the basis of the experience which firefighters and policemen have had where social security has already been extended to or forced upon them.

The point has been made abundently clear that firefighters and policemen have needs peculiar unto themselves. These needs, their best interests and that of the communities require and demand that the exclusion clause be continued and strengthened.

ARKANSAS MEDICAL SOCIETY,
Fort Smith, Ark., May 4, 1965.

HON. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Attached is a resolution concerning H.R. 6675 which was adopted by the Arkansas Medical Society at its recent annual session.

The members of this society respectfully request your consideration and support of their position on these proposed changes in H.R. 6675.

Very truly yours,

PAUL C. SCHAEFER,
Executive Vice President.

Enclosure.

RESOLUTION

Whereas House bill 6675 has passed the House of Representatives in the Congress of the United States and is now pending before the Senate; and

Whereas House bill 6675 provides for a hospital program financed through the social security system, a federally administered medical insurance program and various other health care amendments to the old age and survivors insurance program; and

Whereas the medical profession strongly advocates that the hospital and medical care program should be directed toward those people who are over 65 who need help, that the administration of such program be by the several States rather than federally administered, and that the maximum use be made of private carriers and voluntary health insurance on a prepayment principle; and

Whereas the medical profession strongly opposes a payroll tax on the working man to pay for free health care for those who are not in need; and

Whereas, the medical profession believes that every person should receive the best medical care regardless of his ability to pay: Now, therefore, be it

Resolved, That the Arkansas Medical Society strongly advocates that House bill 6675 be amended to provide for:

1. Medical care for those over 65 who are in need of help;

2. The program being administered by the States rather than the Federal Government; and

3. Maximum use being made of private carriers and the voluntary health insurance on a prepayment principle; and, be it further

Resolved, That a copy of this resolution be transmitted to all of the members of the Arkansas congressional delegation.

NATIONAL ASSOCIATION FOR RETARDED CHILDREN,
New York, N.Y., May 5, 1965.

Senator HARRY S. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: On behalf of the Association for Retarded Children I would like to express to you our support of H.R. 6675 with special reference to the so-called child health amendments which, through various specific provisions, will promote prevention of mental retardation as well as better service to the retarded. There is also included provision for the training of personnel to perform services to crippled and mentally retarded children, an area which has received relatively little Federal support to date.

We also wish to support enthusiastically the amendment to title XVII providing for funds to the States for the implementation of the mental retardation planning, which is now going forward. You will recall that assistance and encouragement to the States to develop planning with respect to the prevention and amelioration of mental retardation in children and adults were initiated approximately 1 year after a comparable effort was initiated in relation to mental illness. One of the most important byproducts of this relatively brief effort to date has been to develop in many states greater cooperation and communication among the various agencies whose services are needed by the mentally retarded. One of the purposes of the proposed amendment to title XVII will be to permit this collaboration to be funded for 2 years at a very modest level during the first stages of putting the plans, so created, into effect. It will also permit some project type grants to the States to carry out interdepartmental studies, surveys, or demonstrations for which the planning process has revealed a need.

H.R. 6675 will, we all know, go down in history as a bill for the health care of the aged. Nevertheless, we feel that its implications for the mentally retarded are most signficant and deserve the bipartisan support of your committee and of the Senate as a whole.

Sincerely yours,

ELIZABETH BOGGS
Mrs. Fitzhugh W. Boggs,
Chairman, Governmental Affairs Committee.

CALIFORNIA STATE CHAMBER OF COMMERCE,
San Francisco, May 4, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: The board of directors of the California State Chamber of Commerce on April 23 unanimously voted its opposition to the payment of benefits for temporary disabilities under the social security disability insurance program and respectfully urges that section 303 be eliminated from H.R. 6675.

The extension of benefits to claimants with temporary disabilities under section 303 would increase the duplication of benefits under social security and workmen's compensation and also increase duplication of benefits under employer-financed group insurance plans and State-operated programs such as we have in California.

Under section 303 many workers would receive, at other workers' expense, more income for staying home than they would by returning to work. Such a duplication of benefits would destroy the main incentive for an injured worker to be rehabilitated. We suggest that section 303 of H.R. 6675 is a harmful duplication of benefits and unwarranted expansion of the social security disability program into fields already being served by well-established programs and should be eliminated.

Thank you for your consideration.

Sincerely,

CLARK GALLOWAY, *General Manager.*

SOUTH CAROLINA RESTAURANT ASSOCIATION,
Columbia, S.C., May 4, 1965.

Hon. HARRY F. BYRD,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: As spokesman for the entire food service industry within our State, we of the South Carolina Restaurant Association go on record as unanimously opposed to section 313 (tax on tips) of H.R. 6675, the medicare bill, presently in the Senate Finance Committee.

We urge you as a member of subject committee to assist in killing section 313 before the bill is released on the floor. Our major objections enumerated below are in harmony with national consensus:

(*a*) Employee resentment with resulting effect on morale and consequent loss of employees accelerating the consistently acute shortage.

(*b*) Withholding from paychecks, the only means possible, would reduce take-home pay and motivate demands for either higher salaries or to have employers to pay the additional taxes.

(*c*) In addition to burdensome bookkeeping and related expense, it is reputed on good authority to take 13 percent of present profits already exceptionally low compared to investment.

(*d*) It would make management of so-called private enterprise an agent of the Government for the purpose of controlling and reporting on funds never in its possession and over which it can only depend on employee integrity—a breeding area for even greater dishonesty.

The National Restaurant Association's position for complete removal of subject section has our full endorsement. We will, however, concede a point as a last endeavor in that an alternate provision might treat tips as self-employment income.

Your support of our position will be deeply appreciated by a great industry striving to survive on an exceptionally low rate of net profit.

Most sincerely,

AMOS W. BECK, *President.*

ATLANTIC CITY, N.J., *May 5, 1965.*

Senator HARRY F. BYRD,
Committee on Finance,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: The following statement is submitted for inclusion in the record of the hearings on the social security bill, H.R. 6675.

The statement concerns only that section of H.R. 6675 which provides for payment of specialized diagnostic services such as radiology and pathology on nonhospitalized patients in hospital outpatient departments. It is noted that this provision does not allow for payment for the same services, rendered to the same type of patient by specialists in private practice.

This seems clearly inequitable at the onset and would have the following unfavorable results:

1. By paying for diagnostic medical services such as X-rays and pathology on nonhospitalized patients only in hospital outpatient departments and not in the offices of private specialists, this provision of H.R. 6675 would tend to destroy private medical practice in these specialties.

2. In this connection, the supplementary plan proposed by the House offers no redress. Under this plan, the beneficiary would pay the first $50 and $25 of the remainder, whereas under the base plan, he would pay only the first $20 and none of the remainder. Further, if admitted to the hospital, the $20 would, in effect, be refunded by being credited to his hospital account. Therefore, the beneficiary would clearly gain economically by getting X-ray studies under the base plan, as now constituted.

3. The specialized medical care in these fields is already in short supply. The increased demand for these services under medicare would deny to the elderly the opportunity of receiving from the thousands of private medical specialists appropriate examinations for their complaints.

4. By placing the entire job of providing such diagnostic medical services solely in hospital X-ray departments to the exclusion of private specialists, this provision of the proposed legislation would overburden the already strained facilities of the hospitals. It would direct a considerable effort of the hospital X-ray departments away from the care and diagnosis of hospitalized patients to handle the increased outpatient load. This would cause delay in providing such services for the hospitalized patients, which would in turn lengthen the period of hospitalization with resulting mounting hospital costs.

5. This provision has serious implications also for the future development of the important medical specialities of radiology and pathology. Even now, these fields are finding difficulty in recruiting trainees. The bill, by tending to eliminate the private practice of these specialties would further discourage young physicians from entering these fields.

6. This provision of the bill would further, deprive both the beneficiaries and the referring physicians from free choice in the selection of diagnostic medical specialists.

It seems obvious that the possibility of such an inequitable and harmful situation arising should be avoided. This can readily be done without changing the purpose, cost, or basic administration of the proposed legislation. The bill need only be changed to the extent of providing payment in the base plan for these specialized medical diagnostic services of radiology and pathology to eligible, nonhospitalized beneficiaries either in the hospital outpatient departments or in the offices of private diagnostic specialists in these fields.

Respectfully submitted.

LEONARD S. ELLENBOGAN, M.D.

WASHINGTON, D.C., *May 6, 1965.*

Hon. HARRY F. BYRD,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR CHAIRMAN BYRD: In considering the proposals of H.R. 6675, or other health programs, there should be concern with economic feasibility, as much as with "actuarial soundness" or "actuarial balance." According to Dorrance C. Bronson's "Concepts of Actuarial Soundness" there is no agreement on the very meaning of "actuarial soundness," although we know it has to do with conditions of "funds" or "reserves." Man, however, is the "forgotten man" when how much is spent, rather than how well it is spent, dominates the discussion. The economist's main concern is not with money but with what money buys; that is, he asks for the best health results at a given cost or the least cost for given health results. He wants to know what is being paid for, why it costs so much, and how to get it at less cost. In actuarial parlance, every benefit to a human being is a cost to a fund but in economic language every benefit has a cost we want to minimize. (We also want to place its burden on those best able to bear it, not necessarily the sick and the disabled.) Economy means not merely fore-

seeing the future, as in a crystal ball or an actuarial report, but shaping the future to get the most from limited resources.

On February 25, Budget Director Kermit Gordon stated before the Joint Economic Committee that "In response to President Johnson's unrelenting pressure for greater efficiency in Government operations, Federal managers are * * * more cost conscious today than at any time in recent memory." He held up the Defense Department as a model, saying: "The cost reduction spirit has caught on in nondefense agencies."

But the cost concept dominating discussion on "medicare" is not the same concept. I wrote Health, Education, and Welfare Secretary Celebrezze that I had "not seen any evidence that 'cost consciousness' as above understood has found any place in the thinking" of his Department. Dr. John W. Cashman, Acting Chief, Division of Community Health Services, Public Health Service, replied that "the Secretary is fully aware of the importance of measuring the economic benefits of specific health programs against economic costs of engaging in such programs." He referred to some "pioneer" studies under Public Health Service auspices. These are good beginnings but I can testify that, at least in the Social Security Administration, study along this line has not been encouraged.

In the Social Security Administration I was instructed to prepare a summary analysis of findings of the University of Michigan study on hospital economics (directed by Mr. Walter J. McNerney, who testified on May 5 before your committee). This was in connection with "mapping out a statistical and research program for the proposed medicare bill." One of the themes to which special attention was to be given was "ways in which an evaluation of reasonability of costs were arrived at."

Because of absence of guidance about the meaning of "reasonable cost" I proceeded to a study of health economics with a view to discovering what this meant. I stated in my report that evidence in the Michigan study, and provided through it, showed there is very little "reasonability" in the actual practice of "Cost Finding for Hospitals" (the title of an accounting handbook recommended by the American Hospital Association). I wrote: "To get 'reasonability' an economic analysis of the subject is required; it is not enough to assume that existing accounting handbooks are adequate."

In the "Report of the Advisory Council on Social Security, 1955," "The Status of the Social Security Program and Recommendations for Its Improvement," the subject of costs other than costs to a fund entity gets less than a page's treatment. This is section 6 of part II (pp. 42–43), "Payments on the Basis of Reasonable Cost." This ends on the following note: "Payments on a reasonable cost basis would be in line with the recommendations of many expert groups, including the American Hospital Association. The established practices of most Blue Cross plans are generally in line with this recommendation." But some, including Dr. Robert S. Morison, director for medical and natural sciences of the Rockefeller Foundation, are critical of prevailing cost studies which are nothing but extrapolations of existing trends. If they are right, we cannot assume current practice represents "reasonable cost."

The printed record of the House Ways and Means Committee hearings on H.R. 3920, King-Anderson bill, "Medical Care for the Aged" (pt. 5, p. 2497), contains my letter to the Continental Casualty Co., asking for "light on the economic principles whereby hospitals price the services they provide." The Ways and Means Committee did not consider this question, but a representative of this company testified before the Subcommittee on Health of the Elderly, Special Committee on Aging of the Senate, on April 27, 1964, that they were not qualified to discuss "the cost of health care itself" (including hospital services); they only considered "the cost of the insurance process; administrative and marketing costs, costs of paying benefits, and a risk charge or profit." In no other economic field would anyone get away with concern only for the marketing of goods to the neglect of their improved production.

"A new science of health economics is taking shape, which must prove itself able to operate at the economic planning level. It must rise above cliches if it is going to assist the medical profession to put its house in order, using some of the methods proved effective by other primary industries" (Journal of Public Health, October 1964, "The Health Industry," by James S. McKenzie-Pollock, M.D., D.P.H.). In other words, the cost reduction goal is just as applicable to the "health industry" as to any other.

A different approach is presented by Mr. Robert J. Myers, Chief Actuary of the Social Security Administration, in his book, "Social Insurance and Allied Government Programs" (p. 7): "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." In other words, no consideration is to be given to the reduction of "the cost of health care itself," as the insurance man put it. Notice, also, the phrase, "benefit cost." This is an actuary, not an economist, speaking.

The Ways and Means Committee inserted into its hearing record other material from me (pt. 5, pps. 2496–2502), raising questions which will become important no matter what the specific measures taken for "medicare." My main concern is that economic reasoning should find a greater application in this area. In my opinion, the discussions before the Ways and Means Committee overemphasized actuarial considerations to the neglect of economic considerations. Actuaries and economists don't always speak the same language, and it is to be feared statements meant in one sense will be misconstrued by those accustomed to think in another sense about these matters.

For example, an article in the December 1964 Journal of Risk & Insurance (pp. 597-602), "An Actuarial Appraisal of Congressional Proposals for Hospital Insurance for the Aged," by Paul E. Hanchett and George R. McCoy, gives an expected shortage of certain services as a reason for lowering a cost estimate. To an economist this would justify raising it. The article points to a difference in utilization, and calls it a difference in "costs." But spending more for health when you are getting more for your money does not mean higher costs. The actuarial terminology makes it seem the rich have higher costs than the poor. In this connection, it should be pointed out that the terms, "high cost," "low cost," and "intermediate cost," as used by the Chief Actuary of the Social Security Administration, accord with actuarial, not economic usage.

This article may be compared with one in the American Economic Review, March 1961 "Hospitalization Insurance and Hospitalization Utilization," by Burton A. Weisbrod and Robert J. Fiesler (pp. 126–32). This distinguishes clearly between increased "utilization" and increased "costs." The Finance Committee may also be interested in this article because it calls into question a prevailing belief that by increasing deductibles you necessarily decrease the total cost of a program. (We must beware of considering only direct, immediately visible costs or benefits, and ignoring such as are indirect or not immediately visible.)

The Senate Subcommittee on Reorganization and International Organizations of the Government Operations Committee (87th Cong., 1st sess., 1961), under the chairmanship of Hubert H. Humphrey, issued Senate Report No. 142, calling for a study of the "overall costs to society of disease and disability." This has hardly been noticed, although the Public Health Service may be credited with taking it as a cue for further study. This report recommends a couple of studies, "Economic Costs of Disease and Injury," by Selma Mushkin and Francis d'A. Collings; and "Does Better Health Pay?" by Burton A. Weisbrod (in Public Health Reports, September 1959 and June 1960, respectively). To these should be added "Toward a Definition of Health Economics," by Selma Mushkin (in Public Health Reports, September 1958).

The Federal Budget of 1965 for the first time had comprehensive figures on health expenditures. This is more than can be said for education, for example. Yet the Council of Economic Advisers, in chapter 4, on "the economic aspects of the Great Society," of its report to the President has a good section on education, but that on health is anemic.

I bring these references to the attention of your committee because they provide necessary economic concepts for judging the performance of any measure in the field of improving health care you may adopt. I request permission to have this letter put into the record of your hearings on H.R. 6675.

Yours sincerely,

SIDNEY KORETZ.

PAN AMERICAN WORLD AIRWAYS,
Washington, D.C., May 6, 1965.

HON. HARRY F. BYRD,
Old Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: Section 303 of the medicare bill is being rushed through Congress without public hearings and with utter disregard for its disruptive effect on other programs. For this and the several following reasons we urge you to eliminate this section from the medicare bill.

Section 303 will double social security's duplication of workmen's compensation and other social insurance programs which would seriously hamper efforts to rehabilitate injured employees and return them to work.

Further encroachment by social security threatens to destroy workmen's compensation, resulting in the major impetus for job safety being eliminated; destroying the financial incentives for rehabilitating and returning the disabled to self-supporting status; and leading employers to expect to become liable for lawsuits charging employer negligence, as they were prior to enactment of workmen's compensation.

Section 303 will impose higher taxes on employers and employees alike.

The hasty and uncritical manner in which section 303 would expand the Social Security disability program into fields already being well served by other programs should be thwarted.

In our opinion section 303 should be dropped from the Medicare Bill until the issues can be adequately examined on their merits.

Sincerely,

BERNARD J. WELCH.

ROSWELL, N. MEX., *May 1, 1965.*

Senator HARRY F. BYRD,
U.S. Senate, Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: It is my understanding your Senate Finance Committee is having public hearing on HR 6675. I would like to give you and your committee my views on this bill.

In spite of the apparent mandate by the electorate for liberal legislation I cannot help but feel the populace has not considered the ramifications of this bill particularly as regards subsidy and control as related to medical care. Undoubtedly there will be great attempts made at broadening this already enveloping legislation. Government will also attempt to fix prices for services rendered, competition will be somewhat stifled, excessive utilization would be the order of the day, and nursing home benefits would become astronomical. There would undoubtedly be great increases in Government subsidy with huge proportions being the eventual rule. This may well aid increased inflation which is already at our door.

Perhaps this would be a good time to voice my most strenuous objection to inclusion of physicians under social security. I for one have no intention of retiring at age 65, provided the Lord allows me to achieve this age, nor do I wish to be supporting a program which I feel is more a tax rather than an insurance program. My estate planning, though meager, has not included this outgo nor source of income. It would be most appreciated if you and your committee would delete this from the final legislation if you approve it.

It may also interest your committee to know that I and many other physicians will not participate in this program even if it is passed by Congress. Perhaps it would also be well for your committee to investigate the amount of governmental control which is already instituted and certainly that which is contemplated since the passage of the bill on area wide planning. It would appear this is a perfect example of a two-page bill passed by Congress which ends up as pages and pages of regulations and control subsequent to the good wishes of Congress. It would also appear this bill is aimed particularly at cutting out competition which has made our American free enterprise system so successful. By this cutting of competition I do not feel you are encouraging thrift but encouraging expenditures. I would feel you have no further to look than the Veterans' Administration for a perfect example of this.

Cordially yours,

HOWARD L. SMITH, M.D.

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF HEALTH,
Frankfort, Ky., May 5, 1965.

HON. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee, Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: Due to the fact that I have had many years of experience in administering the medical aspects of Kentucky's public medical care program under the provisions of the Public Assistance Act, the Kerr-Mills Act, and the Children's Bureau Act, Senator Paul H. Douglas of Illinois requested that I present my views to your committee relating to the State health department being involved in the medical care program under title XIX of H.R. 6675.

I am firmly convinced that the State health departments in the 50 States are uniquely equipped to administer the medical aspects of public medical care programs. This should be done in cooperation with the social welfare agency. Without a mandatory clause in H.R. 6675 to this effect, it will not be done except in a few instances.

In Kentucky, our legislature enacted a State law in 1960 requiring that the social welfare agency and the State department of health enter into a contract for the health department to administer all medical aspects of the program. This includes the setting of standards, the determining of the basis for payment, and the approval of services rendered.

This program has worked beautifully in our State and has tended to elevate the quality of medical care delivered to all the citizens of our State. Our hospitals and nursing homes have made tremendous improvements in the quality of services delivered. The vendor groups in our State are well pleased with the program and we can certify that the eligible recipients are receiving the highest quality medical care available.

In 1963, I was a member of a group of State health commissions who drafted a statement on the role of State health departments in public medical care programs. This statement was adopted unanimously by the Association of State and Territorial Health Officers in October 1963. I am enclosing this statement for the record of your committee.

I respectfully request that your committee give consideration to an amendment to H.R. 6675 which would require the State health departments to participate in administering the medical aspects of the Social Security Act.

With best wishes, I am,

Respectfully yours,

RUSSELL E. TEAGUE, M.D.,
Commissioner, Kentucky State Department of Health.

Enclosure:

SUBMITTED BY RUSSEL E. TEAGUE, M.D., M.P.H., COMMISSIONER OF HEALTH OF KENTUCKY

THE ROLE OF STATE HEALTH DEPARTMENTS IN MEDICAL CARE

A small group of State health officers, concerned with current and future problems in medical care, requested the assistance of the Division of Community Health Services, Public Health Service, in developing a statement on the role of State health departments in medical care. This statement, presented to the Association of State and Territorial Health Officers by its Committee on Health Services Administration, chaired by Dr. Franklin D. Yoder of Illinois, was approved by the Association at its October 1963 meeting with the following resolutions:

The Association recommends the following statement to its members as a useful description of the role of State health departments in medical care, and as a guide in determining what State health departments can accomplish in assuming their proper role in medical care administration and in the cooperative development of facilities and services with all professional, official, and voluntary agencies concerned.

STATEMENT

INTRODUCTION

Definition

Medical care, in a generic sense, refers to the organization and administration of personal health services. It encompasses the system of arrangements and institutions through which health services of a personal nature are produced and delivered to the population.

Patterns

The changing patterns of medical care and the technological, social, economic, and political trends which have influenced its evolution are well documented. In brief, some of these factors are:

1. Increasing technical capacity to prevent disease and to provide effective medical diagnosis, treatment, and rehabilitation.
2. Increasing specialization of health personnel and facilities.
3. Increasing size and mobility of the population and changing age composition, as well as changing morbidity and mortality patterns with increasing emphasis on the chronic diseases.
4. Increasing costs of medical care; expanding economic capacity of the Nation collectively and individually; and progressive removal of economic barriers to the receipt of medical care.
5. Increasing involvement of voluntary and official agencies in financing the availability of facilities, personnel, research, and organization of health services.

Problems

The principal problems in medical care include the following:

1. An increasing fragmentation in delivery of services; artificial separations between preventive and curative services; and depersonalization of the patient through categorical disease emphasis and medical specialization.
2. A lack of comprehensiveness and continuity in patient care resulting from the fragmentation and depersonalization of services.
3. The maldistribution of health services and facilities, and shortages of professional and technical personnel.
4. The absence of a defined locus of responsibility for medical care, which would be responsive to the needs and problems, capable of achieving solutions, and publicly accountable for the results.

Governmental responsibilities

Official agency responsibility for health services to the public does not rest exclusively in health departments. A number of governmental units at Federal, State, and local levels have some responsibility for insuring that the environmental, social, emotional, and biological health of the population is improved or maintained. Some of these other agencies have primary responsibilities for categorical health programs, for example, autonomous mental health agencies or Hill-Burton agencies. Others include health in addition to their primary responsibilities, for example, departments of education or welfare.

Only the official health departments, however, have primary responsibility for the general health of all the people. To the extent that personal health services are less than adequate for any of the people, to that extent medical care is important to us as State health officers.

PRINCIPLES

The basic principles which should guide the role and function of State health departments in medical care include the following:

Goal

The goal of medical care is the provision of a continuum of high quality, comprehensive health services, ranging from primary prevention through rehabilitation, which would be available to each individual when and where he needs them; and without regard to race, color, creed, residence, or economic status, with those able to pay for medical treatment services being expected to do so.

Leadership

The achievement of this goal will require the dynamic interaction of private and public organizations and individuals at all levels of responsibility. Creative,

professional, and responsible leadership in this endeavor is a prime requisite. Official health agencies should be prepared to assume a leadership role in mobilizing and coordinating all resources to improve the quality, availability, organization, and distribution of health services for the population as a whole.

Relationships

We must strive for the establishment of effective relationships among private and public organizations at local, State, and Federal levels, as well as at each level among the various units concerned with medical care. Such relationships should insure that each unit fully utilizes its skills, experience, and resources to strengthen the medical care system and contribute to, but not dominate or fragment, the direction or growth of health services. This should promote the movement of program activity and achievement to that level of responsibility which assures the most effective services, while maintaining an appropriate degree of central leadership, consultation, and coordination.

Flexibility

The State health department role and function should insure that the initiative for planning personal health services arises from within the States and their various communities in order that variations in existing authority, responsibility, and capability will be considered in appropriate relation to local needs, resources, and attitudes.

Priorities

In establishing priorities, we should endeavor to achieve an integrated balance among the substantive areas of service, research, and resource development; and should be guided by present circumstances while anticipating future progress.

Methods

The technical and organizational methods which we develop for any particular medical care activity should utilize and apply the latest in specialized knowledge and skills from the medical, social, economic, and behavioral science fields. The methods should, however, emphasize program requirements rather than special interests of the individual professions in order to apply the generalist approach necessary to achieve coordination.

Standards

The standards of qualitative and quantitative adequacy which we develop for any medical care activity should be defined professionally, implemented realistically, and evaluated objectively.

FUNCTIONS

State health departments have some general responsibility for seven principal functions related to medical care. The scope and type of our specific activities will vary among and within the States, depending upon variations in legal authority, organizational capacity, and historical precedents. However, we all have some degree of responsibility and capability for performance in each of the seven broad functional categories. As new legislation and administrative decisions create the authority for expanded medical care programs and activities, we will be able to use our existing functional capacities as the basis for assuming added responsibilities.

The following outline describes the general functions, and gives examples of activities which some State health departments are now or are capable of performing in each category.

Planning and coordination.—The planning function requires: (1) The exploration of present needs; (2) their projection to the future; and (3) the assessment of capabilities and requirements to meet the obligations through the most effective use of scarce resources. The coordination function is an essential and vital part of planning, especially because a multiplicity of specialized skills is involved within an agency, as well as among the numerous agencies with which the health department relates. Achievement of the goal of comprehensive, continuous medical care demands a high degree of coordinated planning, for which we as State health officers can provide leadership.

Within the health department itself, annual and long-range planning of all activities serves to integrate medical care functions and to coordinate these functions with others of the agency. Because categorical grant programs tend

to fragment medical care activities, some State health departments are developing an organizational structure with single lines of authority and administration which facilitiates the integration of programs. In some instances, this is accomplished by delegating medical care responsibilities to a single unit whose chief is directly responsibility to the department's director; in other cases, a deputy director is assigned to coordinate the medical care activities performed by several departmental units.

In either case, when the internal structure of the State health department defines a single locus of responsibility for medical care, the development of effective relationships with other governmental and nongovernmental agencies is greatly facilitated. We as State health officers are then better able to provide creative leadership for the coordination of all aspects of medical care within our State and with adjacent States and Federal programs.

Collection, interpretation, and dissemination of information.—Adequate and current information is essential for effective planning. Virtually all State health departments are concerned with the collection of vital statistics, morbidity-mortality data, and other demographic information. When we analyze and interpret this information, it can serve as a basis for defining the population to be served and describing its needs. We perform a valuable service by extending these activities to the collection, analysis, and interpretation of data on the utilization of various kinds of medical care, their costs and financing, and the availability and distribution of manpower, facilities, and services. Statistical data may be supplemented with descriptions or case reports of actual programs which demonstrate how certain functions are being performed in particular situations.

Through the communication of this information, the health department performs a vital medical care function both for its own programs as well as those of other agencies. In some instances, the State health department may be the only source and channel for this information. By serving as such a medical care communications center, we can coordinate data from various sources and thus obviate the necessity for expensive duplication of efforts.

Research and evaluation.—The epidemiologic skills of health departments are a valuable and necessary resource for conducting research and evaluation in medical care. They provide a basis for identifying the cause and effect relationsbips among the human, technical, and institutional factors which influence our patterns of medical care. These skills can be applied to the problems of evaluating the capacity of a system for providing services, the quality of performance in a program, and the effectiveness of the medical care provided.

The multiple professional and technical skills which we have available in our departments are well suited for the interdisciplinary approaches necessary for program evaluation, studies and demonstrations of new methods for providing services, and research efforts which can provide new knowledge in the organization, financing, and delivery of services.

State health departments may conduct, participate in, and stimulate research by others to find answers to such questions as: How do people move through the medical care system? How do people go about seeking appropriate care? How does coordination of activities affect patient movement? What is the influence of health education and other channels of information on the use of medical care? How can the quality of care be measured? How can scientific advances best be translated into practice?

Consultation.—As State health officers, we have been charged with the legal responsibility for maintaining and improving the public's health. Communities, other governmental and nongovernmental agencies, and individuals seeking or needing guidance in health matters look to, or should be able to look to, our departments for the trained and qualified personnel capable of providing professional and technical consultation. Welfare departments, vocational rehabilitation agencies, workmen's compensation commissions, and others frequently turn to our departments for advice and consultation in the development, organization, and evaluation of their medical care programs. In some States, for example, the health department advises these agencies on equitable reimbursement rates for providers of service; or it may develop medically sound guides for evaluation of quality of medical care purchased; or it may advise on or certify the providers of services participating in the program. In some cases, we find it possible to loan professional or technical personnel to other agencies or communities when they require consultative services on a more continuing basis.

Some State health departments provide consultation to individual hospitals, nursing homes, or other community health service programs to assist them in developing needed services, improving fiscal or administrative procedures, or generally improving standards to a level which would enable the institution to qualify for licensure or other purposes. Guides and manuals which set forth uniform methods and procedures for various services, for organization and administration, personnel management, cost accounting, and so forth, are also valuable tools.

Resource developments.—State health departments are increasingly concerned with the development of manpower and facility resources for medical care. Scarcity of these resources demands the most effective use of those available, as well as continuing efforts to improve the quantity and quality of their supply.

Some departments provide scholarships or training grants for postgraduate short- and long-term education in medical care administration. Others provide residency training in preventive medicine and community health for physicians and field training experiences for medical and nonmedical administrators. In-service training is also used to retrain or advance the capacities of health department personnel in this field. Increasingly, we are assuming the responsibility for conducting seminars or workshops for the medical care personnel of other governmental and nongovernmental agencies. Institutes for administrators of nursing homes, home care agencies, and other community health services are also presented.

Administration of the hospital and medical facilities survey and construction program is a responsibility of the health department in most States. When this program is coordinated with activities of voluntary hospital planning associations, community health and welfare councils, and other agencies, we have an effective mechanism for developing needed resources and achieving a rational allocation and organization of scarce facilities and services.

Development and maintenance of standards.—State health departments are vitally concerned with functions to insure that the health services provided the population meet at least a minimum standard of quality. We have responsibility for developing and maintaining standards for the quality of medical care provided or purchased by our own programs. In some instances, the standards we develop and maintain may be accepted as the basis for participation by providers of service in welfare department, rehabilitation, Blue Cross, and other programs. When such a situation exists, expensive duplication of efforts is avoided and the providers of services are spared inconvenience and conflicting requirements of multiple inspections for identical purposes.

The majority of State health departments have responsibility for examination, inspection, and licensing of health facilities; some also are responsible for licensing health professional personnel. In some States, we extend these functions to other community health services, such as laboratories, home care programs, and ambulatory services. In at least one State, the health department has been given repsonsibility to undertake confidential medical audits to determine the quality and availability of medical care in the State.

Provision of services.—The scope and type of State health department activity in providing or purchasing direct personal health services varies widely among and within the States.

The equalizing role of State health departments is recognized in some States through their financing, in whole or in part, the services and medical care programs of local health units. Direct personal health services are provided to special population groups, as in maternal and child health programs, crippled children's programs, and school health programs. Some health departments provide services for persons with special diseases, such as venereal diseases, tuberculosis, mental illness, or other chronic diseases. State formula grants, Hill-Burton grants, and categorical grants subsidize such medical care activities for the population in general as areawide planning, hospital construction, multiple screening programs, specialized laboratory or diagnostic services, home care services, and others.

In those States where the crippled children's service program is administered by the health department, it may have a direct concern in providing care as well as in purchasing medical care from those providers which meet the federally prescribed criteria for participation in the program. In a few States, health departments administer the public assistance medical care programs under contract with welfare departments and thus have either direct or indirect responsibilities in the purchase of personal health services for indigent and medically indigent persons.

CONCLUSIONS AND RECOMMENDATIONS

The goal of medical care is based upon a dynamic concept which will change and adapt with new knowledge, methods, and techniques. Achievement of the goal in any one place or time is predicated upon social, economic, and political forces which, in a democratic society, are shaped and given direction by the people. The people, however, must depend upon an enlighted and competent leadership to inform them of alternatives, to guide their choice, and to implement their decisions. They expect, and have a right to expect, that leadership in medical care will come from the official agency which has responsibility for the general health of all the population.

Whatever the amount and source of funds the Nation collectively or individually allocates to medical care, problems of organization, distribution, quality, and administration of personal health services will remain to be solved. We in State health departments should accept our responsibilities for leadership in achieving solutions to these problems, using to the fullest extent our existing and potential resources and establishing close and effective working relationships with other governmental and nongovernmental agencies and individuals at local, State, and Federal levels.

OHIO STATE MEDICAL ASSOCIATION,
Columbus, Ohio, May 7, 1965.

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: In conjunction with the Senate Finance Committee hearings on House Resolution 6675, I respectfully submit to you for your consideration as chairman of that committee, and for the committee as a whole, information pertaining to H.R. 6675.

The purpose of this statement is to provide you and your committee with (1) the position of the Ohio State Medical Association regarding H.R. 6675 and (2) some pertinent facts regarding the important work being done in the State of Ohio to cope successfully with the health problems and other problems of our senior citizens.

The Ohio State Medical Association has consistently supported sound programs, public and private, that are helping to alleviate these problems.

This association consistently has opposed enactment of any plan or scheme of Government-controlled, compulsory health care. H.R. 6675, if enacted, would create a Government-controlled, compulsory program.

Proof that a large majority supports medicine's position on this issue is found in a survey conducted by Opinion Research Corp., Princeton, N.J., March 6 to 21, 1965, which showed 74 percent supporting medicine's position, 14 percent supporting medicare and 12 percent having no opinion.

REASONS FOR OPPOSING H.R. 6675

This association is opposed to H.R. 6675 because such legislation—

(1) is a $6 billion-plus bill written entirely in executive session and recommended for passage without giving the American people their democratic right of speaking out before the House Ways and Means Committee in free and open public hearing;

(2) is totally unnecessary and would become increasingly costly;

(3) would not meet the fundamental needs of the situation: namely, it would not provide the comprehensive program to meet the needs of our senior citizens who need help;

(4) would, by making the Federal Government a direct purchaser of services, destroy the fundamental and important concept of providing social security dollars to beneficiaries;

(5) would lead inevitably and irrevocably to a system of compulsory health care for the entire population;

(6) would lead to the eventual destruction of private and voluntary hospital and medical insurance plans;

(7) would force into hospitals patients who otherwise could be treated on an ambulatory basis;

(8) would enlarge an already huge Federal bureaucracy;

(9) would work additional and unnecessary hardship on young family heads by increasing the already heavy taxes on their incomes at the time when their family needs are greatest; and

(10) would endanger existing and necessary welfare programs since a social security program would likely influence Federal, State, and local governments toward reducing appropriations to finance programs now in operation.

INROADS INTO FAMILY INCOME TREMENDOUS

The inroads into the family income made by the tremendous social security tax increase provided in H.R. 6675 would be tremendous, and would be catastrophic for some families.

The taxes deducted from the worker's pay check would represent what he spends in 4 months for food prepared at home for his family; what he spends in 8 months for clothing for his family.

The self-employed person would be taxed an amount representing 6 months of expenditures for food prepared at home and 11 months of expenditures for clothing.

This can be verified by projecting spending figures printed in the December, 1964, issue of Monthly Labor Review, U.S. Department of Labor, "Contrasts in Spending by Urban Families."

It is brutally socialistic to seize outright this much of a family head's income to attempt to finance a program that benefits the retired millionaire as much as the deserving needy, a program that completely disregards the sound and proper philosophy of helping those who need help.

Pius XI wrote in Quadregsimo Anno, "It is a fundamental principle of social philosophy, fixed and unchangeable, that one should not withdraw from individuals and commit to the community what they can accomplish by their own enterprise and industry. So, too, it is an injustice and at the same time a grave evil and a disturbance of right order to transfer to the larger and higher collectivity functions which can be performed and provided by lesser and subordinate bodies. Inasmuch as every social activity should, by its very nature, prove a help to members of the body social, it should never destroy or absorb them."

The program advocated by the medical profession leaves to the individual the provision of care for himself and his family if he is able to provide such care. Also, it provides for the person needing help the program necessary to meet his needs.

DANGEROUS TO IGNORE ECONOMIC EFFECTS OF TAX INCREASE

The overall economic effects of the huge tax increase that would be levied by H.R. 6675 cannot be ignored if this Nation is to be realistic. The inherent dangers in the diversion of more than $6 billion from present channels, particularly from the income of the worker and management, are considerable.

The economic impact of this proposal in Ohio, for example, based on Department of Commerce and U.S. Census Bureau statistics, would result in additional taxes on employee and employer combined amounting to $311,600,000 in 1966, increasing to $376,800,000 in 1967, increasing to $747,800,000 in 1971, increasing to $992,600,000 in 1973, increasing to $1,010,100,000 in 1974, increasing to $1,190,800,000 in 1980, increasing to $1,394,400,000 in 1987, with continuous increases in the intervening years.

These amounts are in addition to the present social security taxes. Also, these amounts do not include taxes that would be paid by the self-employed.

Another pertinent point is that these direct taxes must come from income the wage earner and self-employed now use to meet day-to-day living and family expenses. The taxes also must come from income the employer, large or small, needs to maintain and improve his business in order to survive in today's highly competitive market.

These figures do not take into consideration any increases in the tax rate that may be necessary to meet cost spirals in the future. History affords us the opportunity of studying the past to avoid mistakes in the future. All one need do is to study the experiences of our Canadian neighbors to realize that this bill would be a tragic economic mistake, notwithstanding the social and philosophical mistakes it would create. I respectfully call to your attention the attached exhibit A, which affords historic fact as to the future dangers this bill would create.

This Nation's social security system was initiated as a means of levying a small tax in order to provide our citizens with a base on which to build their retirement. It was not conceived and cannot be realistically conceived as a full retirement program or a program offering services as well as funds.

The past increases in the social security tax rate, coupled with the multiple and tremendous increases provided in H.R. 6675, threaten to create an overwhelming tax burden against which the American people might well revolt.

It is the opinion of the Ohio State Medical Association that our extremely important social security system must be maintained and financially stabilized on its present basis, rather than be subject to unnecessary and dangerous exploitation that could threaten the entire system.

Again pointing out that history enables us to study the past as a means of avoiding mistakes in the future, I respectfully call to your attention the attached exhibit B, which reflects past increases in both the tax rate and base as well as the many future increases provided by H.R. 6675.

HELPING THOSE NEEDING HELP

The citizens of Ohio believe in helping their senior citizens who need help. This belief was demonstrated 18 months before the social security system came into existence when the people of Ohio voted, as the result of an initiative petition, to establish the Ohio aid for the aged program. This program is and always has been wholeheartedly supported by the medical profession. I respectfully call to your attention the attached exhibit C, which discusses the Ohio program in detail.

The present Ohio program, administered and partially financed by the State, deserves further commendation because it—

(1) provides comprehensive care based on proven needs and local determination;

(2) provides a voluntary, not compulsory, mechanism to supplement, not supplant, individual voluntary health insurance and prepayment plans;

(3 is a "hometown" program administered on a local basis;

(4) is considerably more economical, more sound and more feasible than H.R. 6675;

(5) preserves the physician-patient relationship;

(6) does not detract from the high quality of medical services through third party interference and regulation; and

(7) helps those senior citizens who need help, rather than helping the wealthy equally as much as the needy.

The medical profession readily recognizes that a problem exists in this field. However, considering the number of senior citizens still productively employed or self-employed, plus those already covered by nongovernmental health insurance, plus those who prefer to finance their own health care through their own private resources, one cannot logically conclude that a huge vacuum exists in health care of the aged. The facts speak for themselves.

POSITIVE PROGRAM FOR THE AGING

Fully aware that the medical profession has a major responsibility in this field, the Ohio State Medical Association uses as a guide the following positive program:

1. Stimulation of a realistic attitude toward aging by all people.
2. Greater emphasis on health maintenance, preventative, restorative and rehabilitative services.
3. Accelerate the already expanding and effective methods of financing health care of the aged through voluntary, nonofficial programs and existing programs administered on a State and local basis.
4. Improvement of medical and related facilities for older people, and expansion of training programs to provide additional skilled personnel to staff such facilities.
5. More emphasis on research to help provide solutions for the health and socioeconomic problems of the aging.
6. Stimulation of cooperative community programs for the aging.

American medicine and private enterprise are making great strides toward these goals, once again proving that H.R. 6675 is completely unnecessary.

COMMITTEE ON CARE OF THE AGED

This association long has had an active committee on care of the aged. Many of the 88 county medical societies in Ohio have similar committees. The statewide committee devotes its activities to—

1. consultation with other organizations regarding their activities involving the aging;
2. liaison with such groups and, when requested, advice on the medical aspects of their programs;
3. cooperation with other organizations, governmental and private, in improving health services and facilities;
4. arousing the interests of both physicians and the public, in understanding the problems of the aging; and
5. cooperation in exploring this entire area, including health, psychological, social and economic aspects.

As an example, this committee prepared, in consultation with 17 official and voluntary agencies in Ohio, a comprehensive home care program which has been nationally recognized. Several Ohio cities, through the leadership of their local medical societies, already have established home care programs, and several others are preparing to do so. This development was a direct result of a resolution unanimously passed by the association's house of delegates.

FURTHER EMPHASIS ENCOURAGED

This association encourages further emphasis in the field of the aging through the following constructive programs:

1. Recognize and respect the aging as responsible individual citizens rather than depicting them as a 18-million-member national problem that should be walled off from society. H.R. 6675 would construct such a wall.
2. Immediate abolition of the completely unrealistic retirement-at-65 attitude. Retirement at 65 was developed by Bismarck in the past century when the life expectancy was far less than 65 years, as compared with the present life expectancy of 70 years-plus.
3. Recognition of the skills and productive abilities of older workers, rather than arbitrarily denying them a productive, enjoyable life.
4. Much greater emphasis on mental, physical and financial preparation for retirement during the productive years. Make retirement elective, not compulsory.
5. Continued improvement in income tax laws to ease the tax burden on the low income aged and those who support them.
6. Continuation of insurance on older active workers under group plans, and continuation of group insurance on workers who retire, and their dependents.
7. Continuation, on an individual basis, of coverage originally provided by group insurance, by conversion of policy on retirement.
8. Group policies for groups of retired persons.
9. Development of insurance policies that become paid up at age 65, enabling the policyholder to provide for his retirement health needs during his productive years.

AGE OF PREVENTION

I cannot emphasize too strongly the paramount factor underlying all these programs. This factor is that these programs are all preventive in nature. This is the age of preventive medicine, and the profession and private enterprise are taking the leadership by advocating these programs that either forestall the development of financial problems of the aging, or else provide the means for solution of their problems once they do develop.

In sharp contrast, H.R. 6675 merely offers a completely unsound device that has no preventive factors. Further, it is not an insurance system, but rather is a compulsory payroll tax which undoubtedly the revenues will be insufficient to meet the demands.

The actuarially proven deficiencies of the intended program alone make it a dangerous and unstable venture, regardless of its many other faults.

In summary, there is ample evidence that—

1. the basic problems of the aged, which are much the same as those of any age groups, are being steadily overcome through existing welfare programs, through voluntary programs and private enterprise;

2. more and more emphasis is being placed on adjustment for the older years, medically, economically, socially and financially, through better preparation for retirement during the productive years;

3. more and more attention is being given to those concepts that enable the senior citizen to maintain his own dignity and self-reliance;

4. H.R. 6675 is an attempted hoax that, if enacted, would create far more harm than good; and

5. this Nation's Social Security System must be preserved. The recorded fact is that the several amendments to the Social Security Act over the past years have added benefits to the program that consistently have proved to be far more costly than was anticipated. This has caused considerable inroads into the social security reserves. The money benefits retired persons are deriving through social security play a tremendous role in the economic well-being of this age group. It would be foolhardy to place additional jeopardy on the social security fund by adding another deficit program. H.R. 6675 would be another deficit program.

The Ohio State Medical Association respectfully requests that this statement be presented to the Senate Finance Committee for inclusion in the official record of the hearings on H.R. 6675.

Thank you for your courteous attention.

Sincerely,

ROBERT E. TSCHANTZ, M.D.,
President, Ohio State Medical Association.

(Enclosures: Exhibit A, "Federal Health Estimates—300 Percent Wrong"; Exhibit B, "Social Security Tax Increases, Past and Proposed"; Exhibit C, "Aid for the Aged in Ohio.")

(Copies to members, Senate Finance Committee, and Senator Lausche and Senator Young.)

[Reprinted from the Ohio State Medical Journal, April 1965]

AID FOR THE AGED IN OHIO—HOW THE PUBLIC ASSISTANCE PROGRAM WORKS IN THIS STATE; EXTENT OF COVERAGE; ITS ADMINISTRATION, AND OTHER DATA

(By Clarence V. Tittle, Jr., Chief,[1] Division of Aid for Aged, Ohio Department of Public Welfare)

The Ohio aid for the aged program began in 1934 when it was enacted as a result of an initiative petition passed by a popular vote of the people. It was enacted into being a year and a half before the original Federal Social Security Act.

The first appropriation for Ohio's aid for aged program was exclusively financed by State funds. Since February 1936, it has been financed by State and Federal funds on a matching basis. The program is administered by the division of aid for aged, State department of public welfare, and has an office located in each of the 88 county seats in the State. It is the only public assistance program administered by the State. The 1963–64 appropriation approved by the State legislators for the aid for aged program was $90 million. The appropriation was divided between two major programs—health care and regular assistance programs. Twenty million dollars were allocated to health care and $70 million for the regular assistance program.

SIGNIFICANT CHANGE IN 1956

While the aid for aged program has, since its beginning, made provision for meeting the health care needs of the aged, a most significant change was made in 1956 when the legislators enacted several laws to expand the aid for aged program to make possible the recognition of health care as an extraordinary need without a ceiling on payments. This permitted the division to establish a health care program to meet the health care needs of many aged persons who have the ability to meet their daily living expenses for food, clothing, shelter and

[1] From an address by Mr. Tittle at the Ohio State Medical Association 1965 County Medical Society Officers Conference, Columbus, Feb. 28, 1965.

other items. Now there are about 4,000 aged persons in this State receiving this health care assistance each month through what we call our medical only program. Health care services also are provided each year to 67,000 to 72,000 aged persons who are also receiving regular assistance.

Many can recall that prior to 1956, allowances for health care were included in the recipient's budget, and the total for this item of need could not exceed $200 per year. Since then, there has been no dollar limit on the amount required for necessary health care. There are limitations on the amount that can be charged for various health care services, and these are determined by a fee schedule. As you well know, a wide array of health care services are available to the recipients.

This briefly is an overview of the development of the health care program; but in order to understand better the importance of the program, I would like to point out several trends taking place in the nature of aid for aged caseload.

A review of the caseload since 1934 reveals that several trends are taking place. The caseload of those in need of regular assistance peaked up to 127,106 persons in January, 1950, and has descended downward to 78,665 recipients in December 1964. The average age of the applicant has gone up to 72 years of age, and that for the recipient to 79 years. It is anticipated that the average age of the recipient will reach 80 years within the near future. While the caseload is declining, and an older person is being served, we find a rapid increase in the number of aged persons requiring assistance to meet many kinds of health care needs.

AGING POPULATION INCREASES

This can be clearly seen in the very rapid increase in the number of aged persons requiring assistance to enable them to receive nursing home care. Before 1956, the total number of aid for aged recipients receiving care in nursing home was less than 2,500. Today, there are nearly 12,600 recipients in nursing care homes. Our experience indicates there will be an annual increase of 500 to 600 aged persons needing financial assistance to permit them to obtain long term care in nursing care homes. Presently, the annual expenditure of public assistance funds for nursing home care is $16,800,000. On July 1, 1965, it will reach $18,300,000 when the $10 per month increases go into effect. I will not dwell on nursing home care further, other than to offer you assurance that we are considering three or four plans to improve our program.

How large is the health care program? A look at the payments made for health care services during the fiscal year ending June 30, 1964, offers an insight into its size and the variety of services. We know from the claims submitted that physicians offered their services at least 275,000 times for which we paid $2,624,000. Our statistics fail to show how much of your services you provided without charge, or the extent of services that cannot be measured in any manner. For other practitioners, 25,000 claims were submitted for $120,000 payment. For hospital care 42,700 claims were submitted which represented over 400,000 days of hospital care. The cost of this care was $12,753,000. An aid for aged recipient stays in a hospital an average of almost 14 days per stay. The provision of drugs and supplies which you prescribe cost $4,670,000. If you wonder why you have to wait for your payment, you may appreciate the fact that over 1,075,000 claims were submitted for drug items alone.

Approximately one and a half million claims for all services were submitted for payment during the 1963–64 fiscal year. The total cost for all of the health care services was approximately $20 million in that year. This provided services to 67,000 to 72,000 aged persons receiving public assistance, in addition to the 3,500 to 4,000 aged persons a month on the medical only program.

I have made several references to a medical only program, regular assistance program, and health care program. I am sure that these references are confusing to you and I know they are not fully understood by the public. I feel at times that too many members of the aid for aged staff do not clearly understand the relationship of one to the other.

KERR-MILLS EXPLAINED

The medical only program was made possible through provisions of the Kerr-Mills Act. The legislators of Ohio, and the administration of the State welfare department did not accept the medical assistance for the aged programs as provided in the Kerr-Mills Act. Rather, they selected the provision of the act which

permitted the States to make money payments on behalf of a recipient to another person who has provided health care services to the recipient. The State legislators and the administrators also selected the provision of the Kerr-Mills Act which made is possible to recognize health care as an extraordinary need—one that exceeds the financial ability of a large number of aged persons to maintain themselves on a day-to-day basis.

While Ohio does not have a medical assistance for the aged, it has taken advantage of several provisions of the Kerr-Mills law. One question that I am continually asked is "Would Ohio have a better health care program if it had medical assistance for the aged?"

There is no doubt that by having a medical assistance for the aged program there would be a greater number of persons eligible for health care assistance through liberalization of eligibility requirements by removing the residence requirement and the lien laws. We know that the removal of the lien law would add 10,000 aged persons to our rolls. We do not know how many would be aided by removing the residence requirement.

The argument that by having medical assistance for the aged program, Ohio would gain in Federal matching funds has little merit. To do so in this manner would mean an additional State appropriation that would offset any such gains. It has been our opinion in the welfare department that to adopt a medical assistance for the aged program would mean that we would have to be restrictive by placing drastic limitations on the amount and kinds of health care services necessary to meet the demands made by a sharply increased caseload. Many of the States that have liberalized their eligibility requirements have very limited health care programs. One State only permits three (3) days of hospital care. Recently a large State had to curtail drugs and other services because of overspending.

HELPS THOSE NEEDING HELP

Ohio's medical only program does make it possible for those who are unable to assume the burden of paying for health care costs to have such needs met through the aid for aged program. The payments for such services is made on their behalf to you, the hospitals, druggists, and other health groups.

We have reason to believe that it is a successful program. Last fall I worked very closely with Mr. Charles Edgar and Mr. Hart Page of the Ohio State Medical Association staff to handle inquiries that resulted from your, the Ohio State Medical Association, education campaign which called the specific attention of the aged population to the services offered by the insurance programs and the aid for aged programs. There was a rather heavy response from persons who made inquiry or expressed desire to receive necessary services. In only one case did we find that services were not available in this State to meet the health care needs. This was a most questionable case since the person only very recently moved from another State to Ohio and the health care needs did not appear to be of an emergent nature.

I was very impressed by the concern your staff revealed for the people in this State. I was also impressed with their promptness in responding to you and to those who made inquiries about the various programs. It was a most rewarding experience for me.

Who is eligible for aid for aged assistance?

(1) 65 years of age or older.

(2) Has been a resident of Ohio for three (3) out of the last nine (9) years with 1 year continuous residence immediately prior to application.

(3) Who is in need because he does not have sufficient income or resources for support, including health care costs, and does not have available support from a spouse or child ($84.50 is recognized as the basic amount for food, clothing, rent, and utilities for a single person. Other needs are determined in addition to this amount for a single person living alone. This amount varies considerably according to different living arrangements and various needs).

(4) Who is not living in a public institution, except as a patient in a public medical institution or an inmate of a city or county home.

(5) Whose real estate is not worth more than $12,000. The law requires that both the recipient and the spouse sign a certificate of lien whenever they own an interest in real property. The title is retained by the individual.

(6) A person may retain insurance when its value is $500 or less. Insurance in excess of $500 must be trusteed to the division.

These, briefly, are the eligibility requirements for aid for aged program. They are the same for the medical only program and the regular assistance program.

AREA OF MISUNDERSTANDING

Now I would like to give attention to an area where there is misunderstanding, and that is in regard to the rules and regulations of the division as they relate to you. The staff is instructed, through a written policy, that the private relationship between the physician and recipient is to be respected and protected. The division enters into this relationship only to the extent required to establish need because it is a tax-supported program and to formulate a plan to meet this need within available funds. The caseworkers are instructed to understand clearly that the recipient is the patient of his physician and not of the division. This is the basic philosophy of the division.

I do not believe that we have a rule or regulation that intervenes in your professional physician-patient relationship. The rules and regulations that we do have relate to billing for services rendered and the payment for your services according to a prescribed fee schedule. You are required to bill in triplicate, and the statement should show the recipient's name, address, diagnosis, acute or chronic conditions, date of service, and fees charged. The billing is to be submitted to the subdivision offices within ninety (90) days from date of service. Payments can be made only for no more than two visits for a chronic illness and not more than 10 visits for an acute illness during any one month.

All of these regulations are necessary under present accounting and audit procedures to establish a proper claim against the State. We do have under consideration some methods of simplifying procedures. In case of any dispute, you have the right to request a hearing to appeal the decision made by the division.

ANY JUST CLAIM PROPER

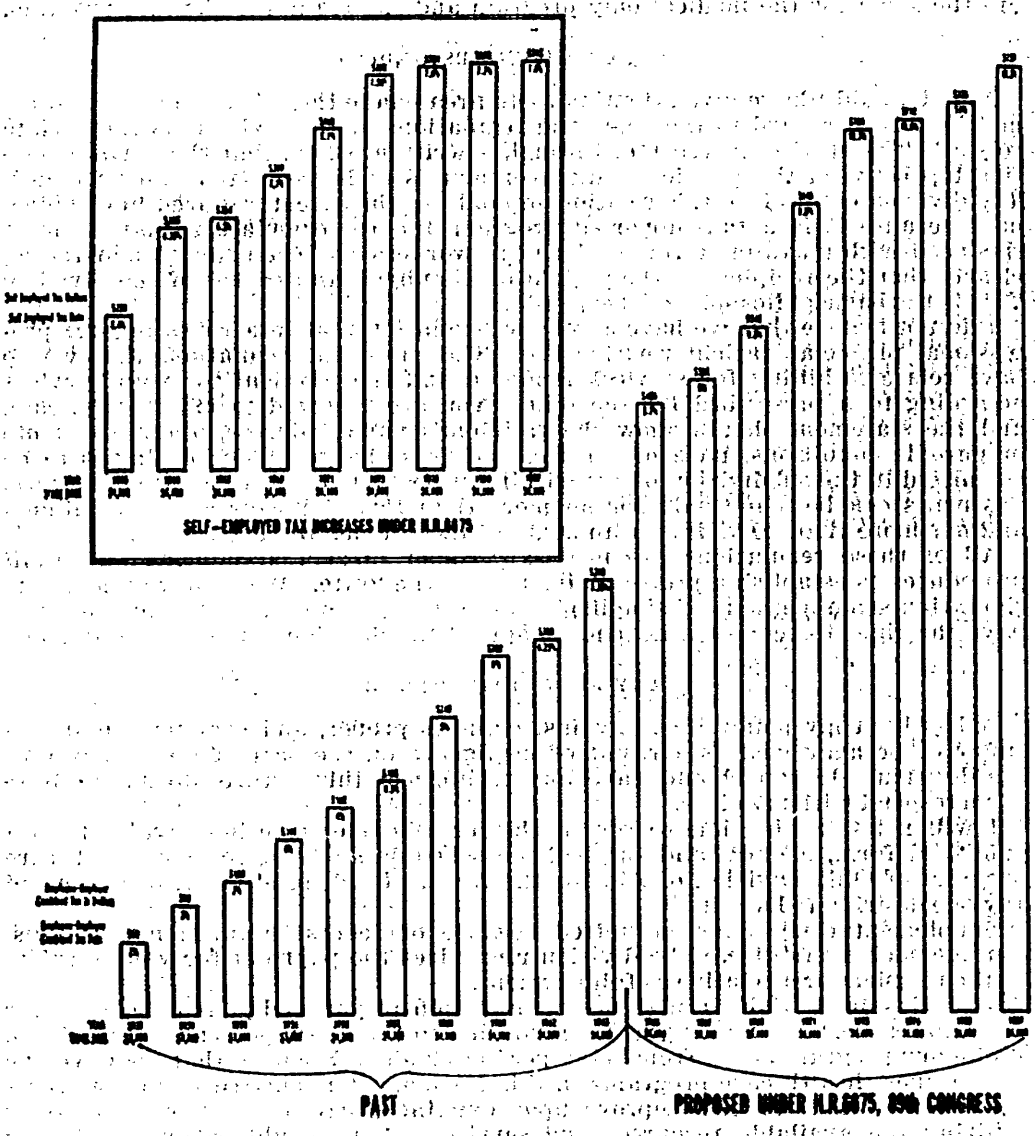
It has been my policy that any just claim is proper, and that no one should suffer or be aggrieved as a result of negligence on the part of an employee of the division. If you should have any feelings of this nature, do not hesitate to correspond with my office.

I will not take the time to review the fee schedule since it is available in a published form, medical and surgical fee schedule applying to new health care program of Ohio Division of Aid for the Aged. I will send the information to any one desiring to have it.

Supplementation is not permitted because of federal regulations that discourage such a practice. The division recognizes the payment for your services by the recipient or a relative as full payment.

In conclusion, I wish to offer my appreciation to you and your colleagues for the valuable services which you are rendering to the needy persons in this State. While our program is far from being perfect or ideal, I believe that we have one of the finest health care programs in this Nation. It is only through our working together that we can improve upon existing programs by more effectively utilizing the available resources and services. You should be proud of your profession and your State organization, and be pleased with your contributions to society. My greatest desire is that more of your colleagues offer their invaluable talents to recipients in our program.

SOCIAL SECURITY INCREASES, PAST AND PROPOSED



[Reprinted from Nation's Business, November 1964]

FEDERAL HEALTH ESTIMATES—300 PERCENT WRONG

MEDICAL COST EXPERT SHOWS GOVERNMENT FIGURES FAR TOO LOW

The true cost of the proposed Federal health plan for the aged can now be told.

If enacted into law, the federally administered plan paid by social security taxes actually would cost at least 3 times what the bureaucrats say it would and eventually perhaps 10 times as much.

This is the conclusion of an authoritative, nonpartisan analysis of the proposed Government health care scheme—one of the major economic and social issues of the day.

The analysis was made by a nationally respected expert who has lived with health and welfare cost estimates during nearly 35 years of Government service. He has just retired after failing to persuade Federal welfare officials to use what he considers realistic methods to find the cost of Government health care.

The authority, Dr. Barkev S. Sanders, made a number of the original cost estimates for the U.S. social security program 25 years ago. He is a medical statistician, sociologist, psychologist, and attorney.

In his analysis for Nation's Business, Dr. Sanders concludes:

"On the basis of all available evidence, even in the first year (of the proposed Federal aged health care program) its cost would be at least 3 times the estimated cost. It is more probable that the multiplier would be 4."

Dr. Sanders points out that the British National Health Service, a more comprehensive socialized medical plan adopted in 1948, ran up expenditures the very next year that were 8 times the cost estimates.

Looking into the future, Dr. Sanders judges that if the U.S. scheme "comes into operation in 1965, the expenditures for it 15 years later would surely be more than 7 times the latest Government actuarial estimate, and it is probable that it would be 10 times more in terms of 1964 dollars."

In part, this judgment is based on the experience of the British health plan which, despite restrictions imposed when actual spending far outran estimates, cost $2.9 billion in 1963.

This was 7 times what the original expense was calculated to be.

An American plan of medical care for the aged certainly would be expended to cover more medical costs and younger beneficiaries than currently proposed, as both opponents and proponents have said. And the wage base on which the social security tax is figured, as well as the amount of the tax itself, almost certainly would be enlarged in line with the historical development of the social security program.

Barkev Sanders, noted medical and welfare statistician-sociologist did study on which this article is based

The proposal—which certainly will be reintroduced in the next Congress—is the remnant left from elaborate and comprehensive government medical and health plans proposed in the 1940's.

When Congress repeatedly beat back these attempts at broad coverage of health services, the strategy of the Government health advocates finally shifted to a flanking movement. This was the present limited hospital, nursing facility and home-care coverage plan for the aged.

The health plan for the aged in recent years has been embodied in the King-Anderson bill. It was approved by the Senate this year, but not the House of Representatives. It is popularly known as medicare although it makes no provision for paying doctors' bills. And it offers potential beneficiaries the choice, cafeteria style and irrevocably, of 45 days, 90 days, or 180 days of hospital care.

Officials of the U.S. Department of Health, Education, and Welfare, who have backed the limited health program and made the estimates of its costs, have testified to Congress that the social security tax would not have to be raised more than about one-half a percentage point of the taxable payroll for both employee and employer. The dollar estimate these officials have offered over the years has ranged between $1 and $1.5 billion annually for the early years of operation. Even by the year 2000, they have declared, the cost would not exceed $2.5 billion annually.

Dr. Sanders' analysis for Nation's Business did not attempt to arrive at a precise dollars-and-cents estimate, since there are too many future variables for anyone to calculate specifically. But his analysis does show that information and methods have been available to Federal officials for years which show their calculations are low to a remarkable degree.

He states in his analysis:

"With respect to its costs, the roots go back again to the early fifties. At that time, the Division of Research and Statistics of the Social Security Ad-

Big jump in hospitalization cost revealed in index of Canadian health program over five years

Provinces	*1959*	*1960*	*1961*	*1962*	*1963*	*1964*
Newfoundland	100	165	178	219	262	305
Prince Edward Island	—	100	226	309	374	430
Nova Scotia	100	519	610	755	860	965
New Brunswick	—	100	173	209	238	276
Quebec	—	—	100	524	637	817
Ontario	100	547	643	795	929	1035
Manitoba	100	158	183	213	243	275
Saskatchewan	100	159	171	189	217	253
Alberta	100	179	193	225	294	323
British Columbia	100	160	176	202	235	264

—All provinces did not begin program the same year

ministration was estimating the cost of hospital care for the aged as one-half of 1 percent of the payroll. And to validate their claim they made a survey of hospital utilization by the aged in 1952.

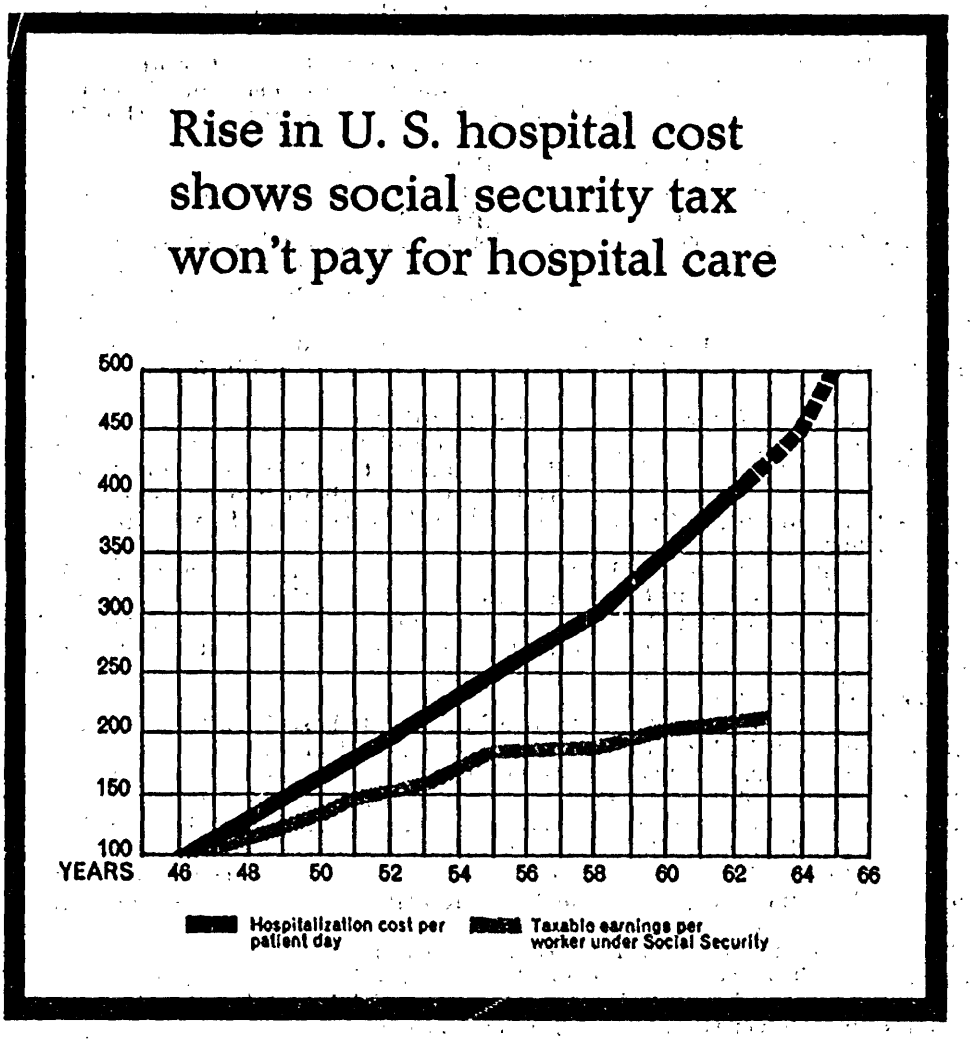
Hospital use in 1952 is still used as the only basis of cost estimates for more recent programs, including the most current congressional bill.

The Federal welfare estimators calculated low and high figures on potential days of hospital use by aging beneficiaries.

But Dr. Sanders points out: "The low-cost estimate includes no upward adjustment for increased hospitalization under a Federal hospital insurance program, while the high-cost estimate assumes at most an upward adjustment of 24 percent.

"These figures indicate that the estimators of medicare costs believe that hospital care received by the aged may be sufficient now, or that at most utilization would be increased by 24 percent under the proposed program. The effect of medicare on utilization as reflected in these cost estimates would hardly support the contentions by the advocates of this program of dire need on the part of the aged for additional hospital services.

"The basic figures giving days of hospitalization were derived from a 1957 old age, survivors, and disability insurance beneficiary servey. This beneficiary survey missed 12 percent of the interviewees in the sample. But nowhere has any attempt been made to determine the characteristics of these missing persons. It is quite plausible that many of these might have been missed because they were confined to some medical institution (including short-term hospitals), or had gone to live with relatives because of infirmities."



This one deficiency alone, if corrected, could add considerably to the volume of hospital services reported.

"Moreover, even the most perfect household survey attempting to record completed hospitalization for a 12-month period is susceptible to large losses, especially if it is for the aged, a significant proportion of whom are institutionalized at a given time."

Dr. Sanders say he spelled out these deficiencies in an official memorandum prepared in connection with the 1952 survey of hospital utilization of the aged, the results of which were to be used as a measure of such use under a government plan.

The character and magnitude of these deficiencies were explained even more explicitly, he says, in a 33-page memorandum dated December 3, 1962, which he addressed to the Chief Actuary of the Social Security Administration with a copy to the Commissioner of Social Security.

HOSPITAL LOAD MISCALCULATED

Free or partially paid hospital care would sharply increase the load of hospital patients over current levels, Dr. Sanders also notes.

"Such an increase would be most pronounced for the initial year, but its effect would be evident at least for the first 4 or 5 years. This increase would not be limited to persons without voluntary, private insurance, as official estimates seem to indicate but would, include those presently insured as well."

Dr. Sanders explains that this seems to be another instance of contradictory thinking by the welfare officials. Despite their frequent claims of the deficiencies of existing private insurance protection, their estimates of the costs for a Federal program are based on the assumpton that those aged presently insured get all the hospital care they need.

"The full impact of medical care insurance in the first year of two," he states, "is reflected in the proportionate increase in costs for those Canadian Provinces for which both the medical insurance program and the Dominion contribution began after 1958. For these the range of increase in per capita costs between 1958 and 1961 is between 51.1 and 98.7 percent.

"Some of this increment is caused by the increase in hospitalization costs, but much of it results from increased use by patients.

"Considering the formula of Dominion payment, which encourages restraints on costs, as well as the fact that provinces remain directly responsible for about half of the insurance costs, and that the level of occupancy in Canadian hospitals is high, it is my opinion that increase in hospital use as a direct consequence of the most recent U.S. Federal hospital care plan would be at the very minimum 30 percent, more probably 60 percent within 5 years or so, and possibly as high as 90 or 100 percent."

In his research Dr. Sanders also compared the estimates of days of hospital use figured in the U.S. Social Security Administration's latest actuarial study with the actual days of hospital care under the Saskatchewan Province of Canada Hospital Service Plan. And these were also compared with estimated days per year of hospital care for aged American veterans in veterans' hospitals and elsewhere.

These comparisons showed that the estimates used by the Social Security Administration in connection with its support of the Federal hospital care legislation were calculated on a basis for about "half the days of hospital care under the Saskatchewan Hospital Service plan and one third of the hospital days used by veterans."

Dr. Sanders also notes:

"The hospital days for veterans are limited to those hospitalized for general medical and surgical conditions. It excludes all hospitalization for service-connected diseases, for neuropsychiatric conditions and for tuberculosis.

"It should be pointed out that veterans are not provided with hospital care for non-service-connected conditions as a right. They are given such care if there are readily available beds in veterans hospitals and if the veteran can demonstrate his inability to pay for such care. It is therefore quite conceivable that under medicare the hospital utilization rate could go well above that found for aged veterans.

"In the government actuarial studies one finds no use made of the veterans' experiences. The veterans hospital study findings for 1957 were available at the time that the Health, Education, and Welfare Secretary's report was prepared in 1959, yet there is no reference to them.

"The Saskatchewan Hospital Service Plan, like the proposed King-Anderson legislation, excludes mental institutions and tuberculosis hospitals and has accommodations for nursing homes. These are not included under hospital days.

"The Saskatchewan experience is not unique. A comparison of the assumed hospital utilization levels for the United States under medicare—without any cutoff—as opposed to that of all Canadian provinces in 1961 and 1962 shows that utilization is higher in every province, except Newfoundland.

"This, we believe, supports our professional judgment that realistic estimates of utilization levels of hospital care would in all probability be 50 to 150 percent more than those used by the Department of Health, Education, and Welfare and later by the actuary of the Social Security Administration."

DAILY COSTS WAY OFF

Dr. Sanders' analysis then moves from estimates of hospital use to actual daily costs of hospital care.

"The report of the Secretary of HEW set a per diem cost of $27 to estimate the cost of paying for hospital services for the aged in 1960." The American Hospital Association which has been compiling per diem costs for its member hospitals since 1946, had much different figures.

"According to AHA, the average per diem cost of all short-term general and special hospitals (exclusive of all federal, mental and tuberculosis hospitals) for the fiscal year 1960 was $32.23.

"In my judgment, a higher rather than lower estimate than the AHA figure should have been made. Over the initial 5 to 10 years of medicare there would inevitably be an inflationary effect on current per diem hospital costs because of heavily increased demand. The Federal experts not only made no such adjustments, but they apparently assumed that the steep increase of hospital costs would disappear in 1960, or at least would be balanced by the increase in wage rates.

"This is an incomprehensible assumption to have made in a report prepared early in 1959, when for the 13 prior years for which per diem hospital payments information was available the rate of increase in hospital costs had been two to three times higher than the increase in wage rates.

"Furthermore, since for cost estimating purposes only the taxable wage rates for social security would be meaningful, this would mean that the taxable wage ceiling would have to be raised frequently, perhaps every year, so as to parallel any annual increase in wage rates.

"In the latest actuarial study, it is said that the cost estimates which have been prepared assume a per diem cost of $37 from 1966 on. This is tantamount to saying that after 1966 the increase in hospital costs would have to be met by progressive annual raising of the ceiling on taxable payroll. Thus, the percentage given in the official estimates has at least two important if's in it.

"The first is whether the $37 per diem is valid for 1966 if medicare were enacted at this time with full benefit payments in force throughout the year. The probable average per diem cost as compiled by the American Hospital Association, without any drastic changes such as the introduction of medicare, would be about $46 in 1966. The stated reasons for reduction in the per diem cost given in the Secretary's report and incorporated in actuarial estimates, even if accepted, could not reduce the average payment for aged patients under medicare to $37.

"The second if is whether the trend in the rate of increase in per diem hospital costs would remain the same. In my opinion, the introduction of medicare would very much accelerate the upward trend in per diem hospital charges relative to wage rates, and would do so in such a way that the cost in 1966 would substantially exceed $46 and the anticipated time when the increase in wage rates will catch up to the increase in hospital costs would be even farther away.

"Those preparing estimates for medicare probably could have found the expected effect of medicare on costs through a study of the Canadian experience. But nothing like this was done."

Dr. Sanders says that in 1959 he prepared a critique of the HEW Secretary's report on the cost estimates. He sought permission to make studies of what would happen with regard to hospital use by the aged if so-called medicare legislation were enacted. He reports that he was given no encouragement. Subsequently his statistical staff was taken away from him without explanation.

Looking ahead for Nation's Business, Dr. Sanders says:

"There is every reason to believe that the steeper increase in hospital costs will continue for the foreseeable future. * * * On the basis of such evidence an eventual increase of 150 or even 200 percent would be more likely over the long range. Besides, the faster increasing costs of per diem hospitalization, the growing liberal use of hospital service, as well as the progressive further aging of our aged population, and medical advances over the foreseebale future would all contribute to this faster upward trend in usage and costs."

The official Government assumptions about hospital days and hospitalization costs of the aged under the most recent proposal can be demonstrated to be unrealistic through another approach.

Dr. Sanders points out the Division of Research and Statistics of the Social Security Administration last year estimated total medical care expenditure, both governmental and private outlays, for those aged 65 and over as $4,015 million in 1960 and $5,355 million in 1961.

"The estimated expenditures indicate that—for 1961—$2,325 million of the total was spent for hospital care and $500 million for skilled nursing home care. Of the $2,325 million total, $495 million is estimated as the expenditure of public funds for mental and tuberculosis hospital services. Subtracting this amount would leave $1,830 million and an allowance of $30 million for private expenditures for mental and tuberculosis hospitals would finally leave $1,800 million as the total expenditure for aged for general hospitals .

"This represents a per capita amount per aged of $106. The 1960 equivalent would be about $98.

"This contrasts sharply with the HEW Secretary's estimate of per capita expenditure in this initial year of Government health care. The cost estimate for hospital care for the aged is given as $762.8 million for an estimated 11.6 million persons aged 65 and over eligible for benefits. This results in a per capita outlay for hospital services estimated at about $66 as opposed to the estimated amount actually spent of $98.

"Another way to look at this per capita figure of $98 is to project it to 1966, and compare the projected finding with the cost estimate in the latest Federal actuarial study. The projection yields a per capita expenditure of $139 in 1966.

"The benefit expenditures, including administrative expenses for calendar year 1966, are given as $1,630 million in the latest actuarial study. The number of beneficiaries is estimated as 18 million for 1965. We can assume that this number would be about 18.4 million for 1966. On this basis the per capita benefit expenditure, according to the actuary, would be $83, or about 60 percent of our estimated amount of $139.

"The actuarial estimate includes the costs of all the other benefits provided under medicare. If limited to hospital benefits only, on the basis of the percentage distribution of taxable payroll costs given for the latest estimates, the per capita amount for hospital benefits would shrink to $72, about 52 percent of $139."

So, if the Federal medicare plan is enacted, one or more alternatives would be needed to pay its costs or make it actuarially sound. Either the benefits would have to be reduced to even more limited health care, or patients would have to pay more of the bills themselves. Or the amount of social security tax or the base on which this tax is levied would have to be boosted sharply.

Dr. Sanders' analysis clearly indicates that the Social Security Administration has avoided a study and presentation of the evidence that would yield the most probable costs of hospital care under the most recent congressional proposal. Under these circumstances estimates of other benefit costs—such as nursing home and home care—probably have little value, in Dr. Sanders' opinion.

The various estimates convince him that these are figures that were selected with only one constraint in mind: "That the overall percentage of the taxable payroll required should not move too far above the 0.5 percent selected back in 1950 as the proper cost for hospitalization benefits for the aged.

"For 1966 the amount of skilled nursing home care for 18.4 million people, according to the Government estimates, would be $68 million, $3.70 per aged. But, according to the 1961 expenditure study (done by the Social Security Administration), nursing home costs amounted to $500 million, or $29.40 per person."

In the light of current usage as well as the increasing rate of demand this $3.70 figure makes little sense.

"For home health services (the third category provided under the Government health plan) the per diem amount would be about $3 per capita. Taking

various cost trends into consideration, this would mean less than one nursing visit or other equivalent services per person every other year. Outpatient-hospital-diagnostic services (the fourth kind of services under medicare) would cost about $1.20 per person. Of course, the patient is required to pay $20 toward this service, but the Government's inclusion of this benefit would cause inflation in the cost of the service, so that the actual cost to the insured would be increased rather than reduced."

Dr. Sanders explains that it is not his purpose to damn a health program for the aged, or to deny a need for it—but rather to convey his personal and professional conviction that "the Social Security Administration has been concealing the truth by means of its actuarial estimates."

He declares that we should not delude the public as to the cost of an effective health program. "If a sound realistic health program cannot be accepted by the public on its merits it should not be imposed on them by the Government."

Dr. Sanders' experience in Government has included service as Chief of the Division of Health and Disability studies in the Office of Commissioner of Social Security, research consultant with the Bureau of Old Age and Survivors Insurance and research consultant with the U.S. Public Health Service.

He was a member of the social security mission to Japan after the war and research analyst with the President's Commission on Veterans' Pensions. He is a consultant to the United Mine Workers Welfare and Retirement Fund. Presently he is doing statistical research for the George Washington University and is consulting actuary with the University of Pittsburgh's Graduate School of Public Health on a special study.

The authoritative opinions and judgments of Dr. Sanders are his own and should not be attributed to any organization or institution with which he has been or is associated.

THE WELCH GRAPE JUICE COMPANY, INC.,
Westfield, N.Y., May 5, 1965.

Hon. HARRY F. BYRD,
Chairman, Finance Committee,
The Senate, Washington, D.C.

MY DEAR SENATOR BYRD: We are in general agreement with most of the provisions of the new social security amendments which have been passed in the House of Representatives (H.R. 6675) and which are now being considered by the Senate Finance Committee.

We also approve of the proposed increases in benefit amounts. We recognize that the continued increase in the cost of living affects those in retirement as much as, if not more than, those in employment. The increase in benefits will help to offset the increase in cost of living. The resultant increased taxes are not unreasonable and, as shown in the actuarial statements, are adequate to maintain the fund.

We have previously supported the disability benefit amendments to the Social Security Act. We feel that a person who is completely incapacitated, as adjudged by competent medical authority, and is unable to work again should be provided with income protection comparable to those who reach retirement age. Our company retirement plan, as do many private plans, includes such a provision. The reasoning is clear and straightforward. The purpose of social security is to provide some means of subsistence when a person is no longer working, due either to age or to total and permanent disability. It is because of this essential purpose that we must register our strong opposition to the proposed amendment to eliminate the "long-continued and indefinite duration" requirement from the definition of disability.

The amendment proposes to permit qualifications for benefits to any person who is disabled for a period of 6 months, regardless of whether that person is expected to recover. The present legislation requires substantial proof of indefinite disability and, in our opinion, it has been very effectively administered. Because of this very logical restriction and good administration, the disability trust fund is currently in favorable balance.

We seriously question the accuracy of the forecasts of the numbers of individuals likely to be affected by this revision. The Research Council for Economic Security revealed, in its 1957 study of "Prolonged Illness Absenteeism," that 19 percent of employed persons from ages 25 to 64 would be disabled more than 6 months. Insurance and actuarial consultants report that 15 percent of all

persons 35 years or over will be disabled for at least 6 months before age 65. It is obvious then that the cost of benefits would place a tremendous burden on the social security program, not only because of the benefits involved for individuals, but because of the vast addition to administrative costs.

We believe the establishment of the automatic 6-month rule for future determinations of disability would drastically increase the overlapping and duplication of benefits from social security and State workmen's compensation laws. We realize that the previous changes in the law eliminated the offset of these two benefits. We did not oppose this change because the basic requirement of total and permanent disability was still retained. The newly proposed legislation would encroach on workmen's compensation coverage since this protection is designed primarily to cover temporary partial or total disability. Social security, on the other hand, is designed for the person who has withdrawn permanently from the labor market, whether because of age or disability likely to result in death or permanence.

In most companies a temporarily disabled employee is eligible for either nonoccupational or occupational benefits, with a 6-month period of coverage generally available to the nonoccupational disabilities. If the employee can expect to receive social security benefits automatically after 6 months, what is his incentive to return to work? This is a real problem, particularly if the employee is receiving workmen's compensation benefits. He could very easily receive more take-home pay from the combined workmen's compensation and social security plans than he would receive if he were employed. All forms of insurance protection against loss of employment income have historically limited payments to a maximum of 70 percent in order not to destroy the initiative to return to work.

After reading the report of the House Committee on Ways and Means, it appears to us that the only justification for changes in the method of disability determination is to preclude the necessity of these individuals to file for welfare payments. This may be a worthwhile aim but we believe it is completely outside the essential purpose of social security.

We believe that the provision regarding the determination of disability should be left unchanged. If there is any justification for a revision, we would prefer to support an improvement in benefit amount for disabled employees as defined under the current definitions. If possible, these comments should be included with your committee's minutes of its proceedings.

Very truly yours,

HERMAN HARROW,
Director of Industrial Relations.

HOSPITAL ASSOCIATION OF RHODE ISLAND,
Providence, R.I., April 26, 1965.

Hon. CLAIBORNE PELL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR PELL: Our group with whom you so kindly met at luncheon in Providence last Tuesday in reference to H.R. 6675 have asked me to send to you, as promised, this letter confirming our hospitals' urgent request for an amendment to the bill before passage, and our key points in support of that request.

In response to your question about the language to amend the bill, I made inquiry to Washington and learned that the following amendment to accomplish what we are requesting has already been suggested:

The AHA amendment: In H.R. 6675, page 64, line 15, after the word "provided," insert the words: "in the field of pathology, radiology, physiatry, or anesthesiology, nor to services provided * * *."

As you know, the purpose of this amendment would be to include under H.R. 6675, in its basic hospital coverage, the radiology, pathology, physiatry, and anesthesiology services which were omitted from the bill in committee before it passed the House.

Unless this serious defect in the bill is repaired, we are concerned for the aged who as patients will promptly and continuingly feel the adverse effects, and we feel concern for the quality of care not only to the aged but ultimately to the entire population.

You are aware, we know, that the services of the above-mentioned four categories of specialists differ from other physician services in that a single specialist (or team of specialists) has the sole use of the extensive facilities for practicing his specialty in a given hospital. Patients coming to such hospital for care must

accept such specialist without choice, if they happen to need the services of that specialty. In return for this privilege the specialist agrees to be responsible to the hospital medical staff and governing body for the administration and supervision of his department and for standards of performance and quality of service.

Because of the potential for economic advantage to the specialists in the situation just described, protection of the patient's interest demands of any nonprofit or public hospital that it exercise some jurisdiction over the amounts to be charged for these specialists' services. In Rhode Island, and we understand the pattern is similar in other States, charges for these specialist services are subject to approval by the hospital governing body and usually are billed and collected by the hospital. The hospital then compensates the specialist according to an agreement which may be based on a fixed amount (salary) or a proportion of departmental income, or a combination of the two.

H.R. 6675 in its present form would disallow such payments by hospitals to these specialists as a reimbursable hospital expense. Result: These specialists while still operating in a privilege exclusive hospital situation, would be "on their own" to seek compensation for services to the aged patients, sending separate bills to these patients without hospital jurisdiction.

Our hospitals know from experience that aged patients would not understand receiving these separate bills which have not up to now been part of the normal pattern; that they would be surprised and dismayed to learn that through legislative "surgery" these customary hospital services they were promised under the King-Anderson bill are to be denied under the basic coverage of H.R. 6675. How high such bills would be, and whether the aged patients would have purchased the optional supplementary insurance or would otherwise have the funds to pay them, are matters for speculation and legitimate concern.

The aged would be adversely affected not only as hospital inpatients but also as outpatients. The basic coverage, under H.R. 6675, includes hospital outpatient diagnostic services subject to a $20 deductible to be paid by the patient. But hospital diagnostic services are apt to be heavy in the categories of X-ray and pathology, both covered only under the optional insurance portion of the proposed act. This optional insurance is subject to a $50 deductible and a 20-percent coinsurance feature. All of this signifies to us that the aged patient, even if he had purchased the optional insurance, would still have to meet out of his own pocket the brunt of the expense for outpatient diagnostic services, whereas he had expected King-Anderson to relieve him of this burden.

By divorcing these specialists from financial responsibility or accountability to hospitals, in such an important piece of legislation, the Congress would set a pattern which would in time adversely affect the quality of care to all patients. Pathologists and radiologists in particular, by the nature of their specialties, are in a position to render valuable assistance to the hospital and its medical staff in measuring and improving the quality of care throughout the institution. By forcing the pathologist, for example, to recover through direct billings to patients the time he spends in performing autopsies or in keeping the hospital medical staff informed of laboratory results which help to reveal the overall quality of care in the hospital, H.R. 6675 would inevitably tend to discourage rather than strengthen such valuable hospital practices.

There have been numerous published statements on the need to amend this unfortunate feature of the bill. Enclosed are two which we consider particularly valid. One is an editorial from the New York Times of March 22, 1965. The other, a statement by Mr. Douglas on the floor of the Senate, appeared in the Congressional Record of March 29, 1965.

Again, we appreciated your meeting with the representatives of our hospitals and your expressed willingness to pursue the matter upon your return to Washington. If we can provide any further information, or if you would like to share with us your appraisal of the situation after you have looked into it, we would appreciate hearing from you at any time.

Sincerely,

WADE C. JOHNSON, *Executive Director.*

[From New York Times, Mar. 22, 1965]

BACKWARD STEP ON MEDICARE

Not everything that has been happening on medicare behind the closed doors of the House Ways and Means Committee has contributed to making it a healthier bill. This became clear with official word that the draft now nearing final approval makes a significant—and expensive—concession to the medical lobby.

The social security part of the measure to provide hospital care for the aged has been revised to exclude physician fees for X-rays, radiology, anesthesiology, pathology, and other services normally billed as part of hospital charges. The change represents a retreat from the original administration proposal—one that not only would reduce protection for the aged but would also undermine the existing coverage of such services in Blue Cross and other hospital insurance.

The House committee's plan to supplement medicare with a voluntary Federal program of insurance against drug and doctor bills does not provide an adequate offset for this new charge. The companion program, though highly desirable, will be voluntary; not all the elderly will be covered and not all their medical bills will be paid. since half the expense of the new program will in any case be met out of general tax funds, the proposed legislation ought to set some check on fees. Otherwise, the cost of all medical care will skyrocket. And certainly the door ought not be opened to enormous additional charges in areas now covered as part of standard hospital service.

Costs of Hospital Services of Radiologists, Pathologists, Physiatrists, and Anesthesiologists Under Medicare

Mr. Douglas. Mr. President, together with many others, I am greatly pleased that the House Ways and Means Committee has reported the so-called medicare bill and that in all probability it is destined for passage. I am also glad that they have added to the basic plan a supplementary plan which will provide for voluntary insurance with costs equally shared by the insured person and the Federal Government to take care of doctor's services and surgical services.

There are, however, defects in the House bill which should be remedied by the Senate. These shortcomings include provisions relating to the administration of the program, as well as the arbitrary exclusion of certain vital and customary hospital services. I expect that the Senate Finance Committee will study in detail these and other questions.

I think it is important to initiate discussions immediately, however, of a most serious and significant defect in the bill as reported by the House committee. This serious defect is an exclusion of hospital services, which, if permitted to become law, would constitute nothing less than direct Federal interference with customary hospital practice.

A cartoon appeared in the St. Louis Post-Dispatch a few days ago which showed a Member of the other body in a surgeon's gown. He had extracted from the patient lying on the operating table a whole series of internal organs. He had them in a glass container, and was displaying it with jubilation to the doctors who were in the surgical amphitheater with the comment, "I got everything out."

One of the fundamental parts of the patient which was taken out—and which should be restored—is payment under the basic plan of the costs of the hospital services of radiologists, pathologists, physiatrists, and anesthesiologists. This is a very serious defect of the bill. Along with others, I hope to seek to restore this feature and others of the original King-Anderson bill as the components of the compulsory system.

Under the basic portion of the House committee's bill, the costs of the hospital services of radiologists, pathologists, physiatrists, and anesthesiologists are excluded as expenses for which the hospital may be reimbursed. I believe this prohibition is unique. It is not found, so far as I can determine, in any other hospital insurance program in this country—public or private. Up to the present, where a hospital bill includes the expenses of services rendered by any of the four medical specialists I have mentioned: first, Blue Cross will pay for it; second, private hospital insurance will pay for it; third, Kerr-Mills public assistance will pay for it; fourth, the Federal employees' health insurance programs will pay for it; and, fifth, the medicare program for dependents of members of the Armed Forces will pay for it.

If we enact the provision now in the committee bill which excludes these services, consistency and logic would seem to demand that we exclude payment for the services of these four specialists from all the health care programs involving Federal financing. There are only two apparent reasons for the exclusion of the services of these specialists as a reimbursable hospital expense. Both reasons are inadequate in my opinion. The first of the reasons for this exclusion apparently involves the gratification of the American Medical Association which has made it clear it does not want to see the services of any

physician covered under health care for the aged—regardless of whether that physician is an employee of a hospital who renders a basic hospital service. The second motivation may be a desire to reduce the cost of the basic health care plan.

The American Medical Association and certain of the specialty boards have had a longstanding dispute with the hospitals of this country over the methods of compensating medical specialists. At the present time such services are billed in a variety of ways—including direct billing by the specialists or the inclusion of these services in the cost of hospital care as a routine hospital expense. If we permit the exclusion now in the House bill to stand, we simply would be taking the side of the American Medical Association and in effect the Congress would join the American Medical Association in its battle with the Nation's hospitals.

To show the full deficiency of this provision in the House committee bill, it is sufficient to point out that the services of these specialists will be paid for under the House bill only under the voluntary insurance portion of the bill and only if a specific fee is charged by the doctor involved. As I have indicated, a number of different methods are now employed in paying for these services. The Congress is being asked to dictate a single method which is contrary to the usual practice and opposed by the hospitals.

Approval of these exclusions would also create a situation which would have an inflationary effect on the costs of health care, an inflationary effect which will probably cost far more in the long run than any savings now apparent in the cost of the basic health care plan.

A principle of the King-Anderson bill has been that hospitals will be reimbursed for the care they provide to beneficiaries of the program on the basis of the costs of services—and not on the basis of hospital charges. This principle is similar to that practiced by many Blue Cross plans. Accordingly, the original King-Anderson bill would reimburse the hospital for the cost of the services of the medical specialists as a routine item, just as do most of the Blue Cross plans. But this accepted and normal method of reimbursement would go out the window if the committee exclusion were permitted to stand. Instead, payment would be made for these services under the voluntary insurance portion of the program on the basis of the fees charged by specialists for each individual patient. In other words, we would be committed to paying whatever charge the specialists might want to make—and not necessarily the actual cost of the service. The inflationary possibilities of this are apparent. Moreover, these provisions of the House committee are inconsistent. They would prohibit the hospital from collecting payment for the expenses involved in furnishing the services of some of its physicians, but would pay the hospital part of the salaries of other doctors through the reimbursement of costs in connection with services rendered by interns and residents—all of whom are graduate physicians. And, many of these doctors—whose salaries the bill would pay—are functioning in the fields of pathology, radiology, physiatry, and anesthesiology. Recent studies show, for example, that only 1,550 doctors of the 7,300 in the specialty of pathology are engaged in private practice, but some 1,800 of these doctors are involved in training programs in pathology. The bill would pay the hospitals for the services of those 1,800 doctors but not for the more than 3,000 pathologists who are either on the hospital payroll or have some other reimbursement agreement with the hospital. This is indeed inconsistent and inequitable.

There is another aspect of this discriminatory exclusion which I find unsatisfactory. It will reduce controls on the quality of care. For example, at the present time, the hospital pathologist can go into a medical staff meeting and tell Dr. Feesplitter that 25 percent of the tissue he removed was normal and that the surgeon had better be more careful in his selection of candidates for surgery. The pathologist has this freedom to criticize because he is paid by the hospital, and his responsibility is to the hospital. This freedom of action would be seriously impaired by the present House provision. The pathologist would be dependent upon referrals from physicians such as Dr. Feesplitter for his income. How critical can he be under such conditions?

I suggest that the Senate consider the following recommendation as one way to resolve the problem I have discussed. This suggestion would have the effect of essentially preserving the variety of methods presently employed in paying for the services of radiologists, pathologists, physiatrists, and anesthesiologists, and it is essentially parallel to the method employed by Blue Cross and Blue Shield in paying for these services. I would recommend that where the hospital provides

the services of the four specialties, the cost of these services should be reimbursable to the hospital under the basic portion of the program. Where the specialist bills the patient directly for his services that charge can be covered under the voluntary insurance section of the program. The status quo would thereby be maintained and the hospitals, doctors, the elderly, and the Nation would benefit.

Mr. GRUENING. Mr. President, will the Senator yield at that point?

Mr. DOUGLAS. I am glad to yield.

Mr. GRUENING. I wish to associate myself with the views on this subject of my good friend from Illinois. I have long felt that while the proposed legislation was highly desirable—and I am a cosponsor of it—it did not go far enough. It was inappropriately named a medicare bill. It has never been a medicare bill, it has been a hospital care bill, and a limited one. It should have been called hospicare.

I am hopeful that when the bill comes to the Senate not only will those excisions of the surgery performed in the House be remedied and that it may survive conference, but that we may have a bill that will have some elements of related medicare as well as hospital care.

Of course, I do not share the propaganda views that come from the American Medical Association that this is some horror called socialized medicine. It will not impose any restriction on the medical profession and, of course, it should not. It is proposed legislation designed to provide long-overdue relief for our aged citizens, the great majority of whom cannot afford out of their savings the high costs of hospital care when incapacitating illnesses of long duration strike one or both in an elderly couple. I know that the country will support it overwhelmingly.

Mr. DOUGLAS. I thank the Senator from Alaska, who is the one "doctor in the house," so to speak although he is a Member of the Senate. He comes from a distinguished medical family and had a fine career in medicine before he went into journalism and then into politics. He knows the real "inside" on this subject.

I may not go for the total range of medical services to be provided but I protest against the elimination of payment for the costs of the in-hospital services of radiologists physiatrists pathologists and anesthesiologists from the original, basic plan of hospital benefits.

In this connection I ask unanimous consent to have printed in the Record at this point an editorial from the New York Times of yesterday, entitled "Universal Stake in Medicare."

There being no objection, the editorial was ordered to be printed in the Record, as follows:

"UNIVERSAL STAKE IN MEDICARE

"The expanded medicare program approved by the House Ways and Means Committee promises benefits that go far beyond more adequate medical and hospital service for the elderly. It will ease emergency charges that have wrecked the budgets of millions of American families; relieve Blue Cross plans of the most expensive item in their cost spiral—the heavy bill for patients over 65—and open the way for badly needed improvements in nursing home care.

"The committee, for so long the graveyard of medicare, has now greatly strengthened the original administration program. Most notable, of course, is its decision to supplement the basic hospital protection with a voluntary program for insuring doctor and drug bills.

"However, some surgery in the Senate or on the House floor will make the measure still better. One retrogressive feature in the Ways and Means draft is the exclusion from the general social security coverage of physician fees for radiology, pathology, and other services now normally billed as part of hospital charges. Such a change will have an inflationary effect on all hospital costs; it will also undermine the trend President Johnson seeks to foster through his overall national health program, toward establishing more comprehensive medical centers with full-time professional staffs. Tighter controls over quality, cost, and utilization also are needed in the medicare program, both for its own sake and for its inevitable impact on general medical economics.

"With these desirable changes, the program can more fully accomplish its enormous potential for contributing to the Great Society." (Quoted from the Congressional Record, Senate, Mar. 29, 1965.)

AMERICAN HEARING SOCIETY,
Washington, D.C., May 7, 1965.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The American Hearing Society, with headquarters at 919 18th Street NW., Washington, D.C., is a national federation of 160 member organizations located in 40 States with a membership of more than 12,000. These affiliated organizations are concerned with rehabilitation service programs for the hearing and speech impaired, including those with retarded language development.

The society is concerned that H.R. 6675 does not include the provision of hearing aids among the medical and other health services provided for in the bill. (See sec. 1861(S), (6) and (7), p. 83.)

From such eminent medical authorities as Edmund Prince Fowler, M.D., director of research, New York League for the Hard of Hearing, New York City, and Samuel Rosen, M.D., ear specialist in surgery of deafness, Mount Sinai Hospital, New York Eye & Ear Infirmary, New York City, we have testimony that a hearing aid is a replacement for the loss of one of the most important senses of any human being and, as such, is surely as worthy of specific provision as an artificial limb. It seems tragically shortsighted to let this bill get by, excluding as it now does, an essential and vital source of help for the large proportion of our elderly population invisibly handicapped by hearing loss.

The initial cost of a hearing aid, averaging $275, is high. Its upkeep is a continuous, on-going expense that taxes the limited income of many of the elderly and/or rapidly exhausts their meager savings. Without an aid, the hard of hearing individual becomes a lost, isolated soul, cut off from contact with his fellow men, unable to participate in educational, civic, or social activities.

Although it is difficult to obtain accurate and reliable figures of the incidence of hearing loss in the United States, it is estimated that there are at least 15 million ranging from mild to severe loss. This is by far the largest single disability category.

An estimated 43 percent have moderate hearing loss. In order to function effectively in personal, social, and occupational situations, they need a variety of specialized treatment, training, therapeutic, and prosthetic services based upon adequate evaluations. Five percent can be classified as severe requiring more intensive treatment, training, therapeutic, and prosthetic services. With respect to age levels of those with moderate to severe loss almost 6 million are adults.

The degree of impairment increases with age. In carefully controlled tests of reliable population samples, 4 percent of those in their fifties have been found to have medically significant hearing loss. Among those over 65, the figure rises to 9 percent.

The American Hearing Society urges the Committee on Finance to amend H.R. 6675 to provide for the provision of hearing aids as one of the medical and other health services which may be provided. The society would like to be recorded in the official record in favor of such an amendment.

Sincerely,

CRAYTON WALKER, *Director.*

NATIONAL ASSOCIATION OF CASUALTY AND SURETY AGENTS,
OFFICE OF THE EXECUTIVE SECRETARY,
New York, N.Y., May 7, 1965.

Senator HARRY F. BYRD,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: On behalf of the entire membership of the National Association of Casualty and Surety Agents, an organization consisting of many hundreds of American independent insurance agents and brokers, and encompassing residents of every State in America, I would respectfully convey to you, and to each member of the Senate Finance Committee, a resolution which was unanimously adopted by our board of directors at its 1965 midyear meeting, held last week in New Orleans, La.

The enclosed resolution is self-explanatory, and we believe serves to point up the inherent dangers in section 303 of H.R. 6675, known as the Social Security Amendments of 1965.

We respectfully urge you and the other members of the Senate Finance Committee to give serious consideration to the ramifications of section 303, in your committee's deliberations on H.R. 6675.

Most sincerely,

BRUCE T. WALLACE.

Whereas the State workmen's compensation system has provided protection for employees and their employers for over 50 years; and

Whereas the operation of the State workmen's compensation system is being increasingly adversely affected by the constantly broadening encroachment of the social security system into the field of work injuries; and

Whereas H.R. 6675, known as the Social Security Amendments of 1965, would greatly expand the area of duplication by making far-reaching changes in the definition of disability under the Social Security Act; and

Whereas no public hearings were held by the House of Representatives or its committees on the adverse effects of this change on workmen's compensation and the other systems of compensating for disability; and

Whereas this change in the definition of disability was unexpectedly inserted in H.R. 6675 and no opportunity was afforded interested persons to be heard or to present amendments after the bill was introduced, few even being aware that this change had been made; and

Whereas no information has been made available as to the cost of this proposal, its adverse effects on the rehabilitation of individuals injured in industry and the prevention of industrial accidents and diseases; and

Whereas this amendment would have a most serious impact on State workmen's compensation laws; and

Whereas H.R. 6675 is now pending for action before the Senate of the United States and hearings on this measure will be held by the Senate Finance Committee beginning in the very near future: Now, therefore, be it

Resolved, That the board of directors of the National Association of Casualty and Surety Agents, assembled in midyear meeting this 29th and 30th of April 1965, hereby records its opposition to the broadening of the definition of disability as provided in section 303 of H.R. 6675 and that the membership of the National Association of Casualty and Surety Agents is urged to convey to their Senators and Congressmen their conviction that section 303 of this bill should be eliminated or an appropriate offset for workmen's compensation inserted; and be it further

Resolved, That a copy of this resolution be sent to all members of the National Association of Casualty and Surety Agents and an appropriate statement in accord with the sentiments of this resolution be presented to the members of the Senate Finance Committee.

CURATIVE WORKSHOP OF MILWAUKEE,
Milwaukee, Wis., April 19, 1965.

Re legislation on health care for the aged, H.R. 6675, and corresponding Senate bill.

Senator WILLIAM E. PROXMIRE,
Senate Office Building,
Washington, D.C.

HON. SENATOR PROXMIRE: I was requested to write you on behalf of institutions similar to the Curative Workshop of Milwaukee who are concerned over the Federal legislation on health care for the aged recently passed by the House of Representatives and shortly to be considered by the U.S. Senate.

We are concerned that the proposed Federal legislation will clearly specify that outpatient treatment institutions and rehabilitation centers like the Curative Workshops of Milwaukee, Green Bay, and Racine, and other similar institutions who engage certified physicians, physical, occupational, and speech therapists, will be included as eligible renderers, or providers of physical, occupational and speech therapy services for the aged. We may add that, in addition to the outpatient services, the Curative Workshops of Milwaukee, Green Bay, and Racine, also operate home service programs. Under a physician's pre-

scription, they provide physical, occupational and speech therapy services to the aged in their homes to keep them functioning at maximum levels in independent living activities and homemaking functions.

During the 1964 fiscal year, the Curative Workshop of Milwaukee served 3,986 different persons of which about 18 percent, or 717 of these patients, were 65 years of age or over. I believe you will find a similar distribution of patients at the Racine and Green Bay Curative Workshops.

During the past 45 years of its existence, the Curative Workshop of Milwaukee's certified therapists have served thousands of aged persons on an outpatient basis and in their homes, restoring them physically and keeping them functioning on a maximum level at a minimum cost to themselves and the taxpayers. These medical and rehabilitation services have prevented or reduced costly hospitalizations and other medical procedures, but most important, these services have helped to keep the family units functioning harmoniously together, prevented dependency among the aged and kept many of the aged out of costly institutions.

We are proud of our contributions to the aged population and ask that you make certain that this legislation will clearly include the purchase of physical, occupational and speech therapy provided by certified therapists under a qualified physician's direction from our respective institution, on an outpatient and home service basis.

We will appreciate hearing from you at the earliest convenience.

Sincerely,

T. S. ALLEGREZZA, *Executive Director.*

STATEMENT OF ORVILLE F. GRAHAME, VICE PRESIDENT AND GENERAL COUNSEL OF THE PAUL REVERE LIFE INSURANCE CO. AND THE MASSACHUSETTS PROTECTIVE ASSOCIATION, INC., OF WORCESTER, MASS., TO THE SENATE FINANCE COMMITTEE ON H.R. 6675 RELATING TO THE SOCIAL SECURITY AMENDMENTS OF 1965 WITH PARTICULAR REFERENCE TO SECTION 303 OF H.R. 6675

Our organization has been in the accident and health insurance business since 1895 and is one of the largest writers of guaranteed premium noncancellable and guaranteed renewable coverage. We are licensed for both companies in all States and the District of Columbia, and we also do business in a number of the provinces of Canada.

The issues discussed in this statement.—We object to both the change in the definition of disability and to the provision to pay for the sixth month of disability, as set forth in section 303 of H.R. 6675.

We are very much concerned that the proposed amendments, while perhaps suggested as technical amendments, will seriously interfere with the offering of disability insurance coverage on a private insurance basis.

Qualifications of writer.—The person making this statement is a lawyer and fellow of the Insurance Institute, and has been and is active in both life and health insurance trade associations organizations dealing with social security legislative problems, and currently is chairman of a trade association legislative committee dealing with State problems.

The writer also has been active in a number of conferences and committees on a local, State, university, and national basis which considered problems of the aging. This included membership on the National Advisory Committee of the White House Conference on Aging in 1961. His assignment at the Conference was to the Planning Committee on Income Maintenance headed by Dean Charles I. Schottland, former Commissioner of Social Security, Department of Health, Education, and Welfare. In addition to chairing a work group, he was a member of the Recommendations Committee of the Income Maintenance Section which made a number of specific recommendations including a position on financing of medical care, all of which he supported.

His personal support for this "progressive" position was on the premise that for persons under age 65 private industry was doing and could do an efficient and effective job on health care and in the field of disability insurance, and would be permitted and encouraged by government to do so. Thus, in the political spectrum, the writer would like to be considered to be in the middle of the road, believing there is a proper place for both government and private industry in the social security area, a position he supports in the National Council on Aging.

Government disability insurance does not help private insurance.—It cannot be argued successfully that Government disability insurance is a "good thing"

for private insurance. In life insurance it is difficult to be overinsured as few can pay the full premiums, and very, very few wish to die right away to collect. So life insurance can be piled on some moderate amount of social insurance. However, in disability insurance in the lower income brackets there is no upper layer of income to insure due to the fact that experience has shown it is unwise to pay a man as much, or nearly as much, disabled as you would pay him if well and working. In disability insurance he is free on the basis of subjective symptoms to elect nonemployment or early retirement. Hence, we do not like to insure over 60 to 80 percent of a man's income, especially considering that disability benefits, both Government and private, are not taxable.

Disability benefits were provided under the Social Security Act in 1956. At that time there were 41,688,000 persons reported to be covered with private loss of income disability insurance coverage. This had gone up from 26,229,000 in 1946. In 1963, the total was only 46,056,000. It would thus appear, even though the total work force has an upper limit, that the disability provision in the Social Security Act may well have deterred the growth of private disability insurance.

CHANGE IN DEFINITION OF DISABILITY

The elimination of the provision for long-continued and indefinite duration of the disability in the present law admittedly may give some help in administering the law on certain problems but probably will bring some other difficulties. Senators and Congressmen may have received complaints on the present provision, but that is in the nature of disability insurance. There will be complaints galore in any hospital or medical plan for people over age 65. There well may be more complaints under the proposed language for disability than now since people can differ on the fact of disability, and there will not be the same language support for any Government contention of nonexisting disability.

The contention that private insurers use such a clause as proposed is generally true, but this raises the basic question of whether Government intends to take care of early retirement due to disability, or whether it intends to go into a competing temporary disability insurance business.

There is also another question not answered to our satisfaction. Is there not another possible remedy for the case where no one knows whether or how soon a disabled person will recover from disability? Perhaps in such cases a decision could be made on some other test, as (1) hospital or house confinement for a specified period, or (2) total disability for a longer period, as 2 years, as a supplement to the long-continued and indefinite duration requirement.

The proposed language will remove a large area of the market for private insurance. It is not believed that the Congress intends this consequence. Some feel we are not dealing with the issue of a floor of protection but with the nationalization of disability insurance.

PAYMENT FOR THE 6TH MONTH

The payment for the 6th month is also an amendment probably intended to facilitate administration, but it is especially irritating to private insurers, as it is a definite further step into the field of disability insurance. Many group plans pay for 26 weeks or 6 months. There are also workmen's compensation complications being called to your attention. Several States have cash sickness plans covering 6 months. This overlap of benefits is socially undesirable.

If it is contended that an "administrative" change is needed to pay for the 6th month, it can be argued later it ought to be made to pay for the 5th month, the 4th month, and so on.

If the waiting period has been served, and the 7th month of disability has transpired, no one objects to prompt payment. Also, if there is any part of a fractional month of disability that is ignored, some way should be found to run the 6 months from the commencement date of disability. Private insurers do that. Otherwise, we suggest the law should stay as it now is.

Not thoroughly considered.—The Forand bill, the King-Anderson bill, and the other bills on "medicare" resulted in much consideration of the pros and cons in countless conferences, TV debates, and in the Halls of Congress, and indeed in several presidential campaigns. There has not been time or the opportunity to carefully consider these disability amendments. It is believed this is true of those advocating them and of those who are critical of them. Certainly, the public has had no chance to consider such amendments, and we have not heretofore had any opportunity to discuss such amendments with Members of the Congress or with the Department of Health, Education, and Welfare.

RECOMMENDATION

In view of the foregoing, we sincerely and strongly recommend that the above-mentioned amendments contained in section 803 of H.R. 6675 be deleted (or altered in some way as suggested to solve any reasonable administrative problem) without changing the basic nature of the benefit.

Respectfully,

ORVILLE F. GRAHAME.

STATEMENT OF THE AMERICAN COLLEGE OF RADIOLOGY SUBMITTED BY WALLACE D. BUCHANAN, M.D., PRESIDENT

The members of the American College of Radiology appreciate the opportunity offered by the Senate Finance Committee to support provisions for payment for physician services in the field of radiology and three other specialties in the voluntary medical care insurance section of H.R. 6675, title XVIII, part B, now pending before the committee.

The members of the American College of Radiology favor retention of the language in H.R. 6675 and are opposed to any amendment of the bill which would define their professional services as hospital services under title XVIII, part A, or provide for compensation for physician services through hospitals or other institutions.

This statement will be confined to this important matter.

The members of the American College of Radiology are 6,200 doctors of medicine, more than 90 percent of those who specialize in radiology in the United States, and also the 1,400 physicians currently in training in this specialty. The opinions expressed in this statement are based upon actions of college deliberative bodies.

The practice of radiology is the practice of medicine and is so recognized by all medical associations, within Government medical services, by courts and other agencies of Government. Radiologists have completed a 4-year course in medical school, a year of internship, a training program in the medical uses of X-rays and radioactive materials of from 3 to 4 years, and have passed an examination by a special certifying board in the field of radiology.

In medical uses of radiation, a physician must in each instance decide whether the possible gain from exposing the particular patient outweighs the hazard of use. Only a doctor can evaluate what is a sufficient medical return to the patient for the radiation expended. This is a medical decision, not administrative. Such decisions should not be placed under control of hospitals. This professional nature of medical radiology is recognized in the educational programing of the USPHS. The definition of radiology as a hospital service in a Federal law would inhibit efforts of the profession and the Government to improve medical uses of radiation by physicians.

Ten to fifteen percent of the practice of radiologists involves the treatment of various diseases, chiefly cancers. Approximately 70 percent of all patients developing cancer are treated with radiation by radiologists. In treating with radiation, adequate equipment is desirable and necessary but the apparatus is far less important than the competence of the physician using it. The radiologist must decide whether, how and when to treat each individual patient. The patient's age, sex, physical condition, psychologic state, family situation and the like, all have a bearing on medical decisions that must be made. This is the art of medicine, and it has a tremendous influence on whether and how a patient reacts to treatment.

The report of the President's Commission on Heart Disease, Cancer and Stroke repeatedly recognizes the vital role of radiologists in the treatment of cancer, and the necessity of increasing the number of trained radiotherapists. The report says in part, "With properly trained radiation therapists available, improvement in most of the cure rates would be immediately possible for those patients with lesions suitable for such treatment."

Eighty-five to ninety percent of radiologic practice is the diagnosis of human illnesses. At least one-fourth of all important decisions in medical practice are based upon the interpretation of radiologic examinations. With X-rays and radioactive isotopes, radiologists are now examining every system of the human body. In performing physical examinations of patients by using X-rays, we personally do all fluoroscopy, interpret every film made, dictate a report on every examination, consult with other physicians, and many of us inject the drugs

used in complex procedures and wait with patients to handle adverse reactions.

In both diagnosis and treatment, the physician's service needs to be individualized for the particular patient, and the medical decisions of the doctor should not be placed under the administrative control of a nonphysical administrator, or board of trustees. Adoption of amendment 79 would establish such administrative control.

Radiologists also occupy a vital position in radiation safety and protection, a field which involves the future of the human race. Better and safer uses of radiation in medicine, agriculture, astrophysics, biophysics, commerce, and in the military require radiologic guidance. Radiologists have supplied leadership in radiation protection in the United States and internationally for more than 40 years. These services are provided by men, not machines. The total investment in radiologic installations is all but valueless without the radiologists who must interpret the data produced by the installations. The machines and X-ray films are merely tools, and the technologic personnel are helpers of the medical radiologists.

As physicians, radiologists practice in many settings to make their services available to all types of patients. Many operate private offices. Some have private offices and also practice in one or more hospital radiology departments. Some are in clinic practice and others are teachers in medical schools. All regard themselves as physicians and regard their services to patients as medical services. These services are the same, regardless of the site.

The entire medical professional realizes that to define the radiologist's professional service as a hospital service would impair his performance as a practitioner of medicine, just as the services of the general practitioner, internist or surgeon would suffer if his services were so defined. Radiologists are human beings. For high morale and best performance, they must be able to work with dignity, be on a par with other doctors and enjoy professional freedom.

Some of the reasons not to define a physician's practice in radiology as a hospital service are as follows:

1. A radiologist, or any other physician, performs best under circumstances which permit freedom from administrative interference in the service he performs for the individual patient. The members of the American College of Radiology are convinced that the forced placement of their professional services under hospital control as proposed in amendment 79 would result in domination of their specialty by hospitals. This, they feel, would be contrary to the public interest, and the interests of individual patients, the sick persons who are the primary concern of all doctors.

2. Radiologists know that the difficult task of recruiting bright young doctors into radiology in the face of the appeal of other medical specialties has been made harder because of the continuing unrest between radiologists and hospitals, and because of the threat of being segregated from medical practice by definition as a hospital service under a Federal law.

Current recruitment for radiology returns an increase of some 5 percent yearly over deaths, including foreign physicians who often return to their own countries. At the same time, the uses of radiology in the diagnosis and treatment of diseases has increased more than 12 percent annually for many years. The increasing complexities of new procedures, such as intricate heart examinations, makes the actual increase in the radiologist's time expended closer to 20 percent. In 1963, only three out of four openings in radiology training programs for physicians were filled. The percentages in the surgical specialties and internal medicine were much higher, while programs in pathology and anesthesiology also went relatively unfilled. In 1958 there were, 1,389 physicians in radiology residency training programs, and in March 1964, there were only 1,395. During this same period of time, the volume of radiologic examinations in hospitals increased 72 percent.

Radiologists believe that this is a clear indication of the impossible recruiting task they will face if amendment 79 is adopted. We will not be able to attract men into a specialty defined as a hospital service.

3. Radiology services are covered in most Blue Shield plans (65 out of 71 in 1963) along with services of other physicians. This has assisted patients in financing health care and has not disrupted medical practice or hospital administration.

Radiologists would have preferred to have the total payment for their services placed in the voluntary insurance portion of H.R. 6675, and then to reimburse hospitals for space, supplies, personnel furnished, etc. We believe that this

would provide maximum physician control over the service rendered to each patient. We recognize, however, that the House of Representatives in adopting H.R. 6675 believed that such treatment of our specialty would differentiate it from surgery, general practice and other branches of medicine. In H.R. 6675 the hospital directly collects its costs for the operating room, the hospital bed, the radiology department, and drugs provided to patients served by surgeons, generalists, radiologists, etc. The House of Representatives decided to treat all physicians' services alike and all hospital costs alike. We accept this equal treatment under the law and oppose the discriminatory treatment explicit in amendment 79.

In 1965 medical practice is highly interdependent. If radiology is downgraded by definition as a hospital service, medical care available to all patients in all branches of medicine will suffer.

4. We are basically interested only in high level radiology services for patients now and in the future. We cannot now provide such under hospital domination, and we cannot recruit bright young doctors to provide such in the future if we are excepted from the practice of medicine under a Federal law. In the practice of radiology there is in each instance a patient and in each instance a radiologist who, as a physician, is directing his best efforts toward nothing but the diagnosis, or treatment, of that individual patient. This is the relationship we wish to have with patients over 65 under H.R. 6675; we do not wish to face them as hospital employees with conflicting responsibilities to hospital corporations. We are anxious to work with hospitals, Government, and insurers to provide the best possible medical care to patients at a reasonable cost within the terms of the law that is passed. We are ready to so cooperate now, or at any time in the future. We ask only that we be allowed to do this as doctors of medicine under the same terms as the Congress provides other physicians under the same law.

EXTEND TO THE DISABLED BENEFICIARIES THE SAME HEALTH CARE PROVIDED TO THE AGED IN H.R. 6675, STATEMENT OF REPRESENTATIVE CARL D. PERKINS OF KENTUCKY

Mr. Chairman, I appreciate the opportunity to appear before this committee to express my hope for favorable consideration of the bill, H.R. 6675, which would provide a broad program of health care for all people in the country when they reach their 65th birthday.

My purpose in appearing before you today, however, is not to comment in detail on the merits of the legislation passed by the House, but rather to urge that the benefits contained in the House bill be extended also to those disabled persons who are now drawing social security benefits and those who will qualify in the future. The report of the advisory council on social security, which appeared in January of this year, made such a recommendation as one of its proposals for the logical improvements at this time of our existing social security structure. This council made up of 12 outstanding authorities representing labor, the insurance industry, the medical profession, industry, public welfare, and experts in the university world, concluded:

"Hospital expenses are a serious problem for the totally disabled too. Like the aged, they too are hospitalized frequently and in many cases their hospital stays are long. According to a survey of workers found disabled under the social security disability provisions (conducted by the Social Security Administration in 1960), about one out of five disability beneficiaries under social security received care in short-stay hospitals in the survey year; and, excluding hospitalizations in long-term institutions, half of those hospitalized were in the hospital for 3 weeks or more."

For this reason recommendation number II of the report reads, in its first sentence, "The council proposes hospital insurance protection for those 65 or over and for disabled social security beneficiaries."

Mr. Chairman, I am aware of the fact that most previous proposals for health insurance for the aged have not included the disabled but it has always seemed to me to be a major oversight of these proposals. It is hard for me to understand how we can exclude from the program the relatively small group of people who have been adjudged by the Social Security Administration to be so seriously handicapped that their infirmities entitle them to benefits because they are unable to work. As we know, the definition for determining disability is a very strict

one—too strict I have always believed. But the fact remains that, because of the strictness of that definition an extension at this time of the medical care provided in this bill to the some 910,000 disabled workers now drawing benefits would seem to be a relatively small but highly important addition to the legislation.

It is hard for me to understand why those victims of a severely crippling accident or illness, arising out of circumstances beyond their control, have been so often overlooked in our consideration of social security legislation through the years. One of my first concerns, when I came to the Congress in 1949, was to extend the protection provided by the cash benefits program to these people. I introduced a bill into the Congress to accomplish this purpose into that, and subsequent Congresses. But not until 7 years later, in the 1956 amendments, were we able to prevail in that area. Now that we are reaching the final weeks of consideration of another very important broad step forward in the structure of our social security system—the addition of a health insurance program for the aged—I would hope that the disabled will not again be overlooked. I urge this committee, in its wisdom, to make this reasonable addition to the bill when they report it to the Senate.

STATEMENT TO THE SENATE FINANCE COMMITTEE BY THE PRESIDENT OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

The Medical Society of the District of Columbia believes that House bill 6675 is a progressive step in the field of health care. The executive committee and a special committee of our medical society have evaluated H.R. 6675 in considerable detail. Being practicing physicians, we are not accustomed to legislative language; nevertheless we believe that any Federal legislation in the health field should have the following goals:

First, simplicity of legislation so as to provide ease of administration.

Second, provision for as adequate a program of medical, hospital, and related health services as is feasible.

Third, a minimum of interference by any "third party," especially a Federal agency of large dimensions, between patient and physician.

With these in mind this medical society has officially endorsed, as long ago as last November, a Federal program for those over 65 years of age based on a proven Federal Government program—the Federal Employees Health Benefits program. This program has been in operation for 5 years and covers not only Federal employees but also Federal retirees, roughly 6 million people.

In comparing this program with the proposed bill, the following points seem important:

The FEHB plan is more simple in administration than H.R. 6675. Experienced administrative agencies are already functioning.

It has proved to be adequate "benefitwise," and when supplemented by an implemented Kerr-Mills law would cover practically all possible needs of health care.

It in no way interferes with the patient-physician relationship, and leaves such controls of medical practice as are necessary in the hands of an experienced and proven system already in operation.

Physicians, hospital administrators, and others in the health field are acquainted with the FEHB program—its benefits, limitations, and operations.

Such a program would act as a buffer between the Members of Congress and their patient constituents.

It is therefore the recommendation of the Medical Society of the District of Columbia that the Senate Finance Committee give consideration to the use of an FEHB type of program for both hospitalization and physicians' services. It is further recommended that provision be incorporated in the bill for payment of fees to be made in part or in full, depending upon the income status of each individual; the latter to be determined by a simple declaration or an income tax duplicate.

PAUL R. WILNER, M.D., *President.*

MANCHESTER MEDICAL SOCIETY,
Richmond, Va., May 8, 1965.

Senator HARRY FLOOD BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: The members of our society voted unanimously at its meeting May 4, 1965, to oppose attempts by Congress to classify or cover any portion of physicians' services as hospital services under S.I., and to oppose amendment of H.R. 6675.

Hospitals, their administrators, and governing boards are not prepared to practice medicine or to furnish medical services; are not licensed to practice medicine; and Virginia's laws prohibit the practice of medicine by hospitals.

Where hospitals are employing physicians so that the hospital controls and furnishes the services of physicians in radiology, pathology, and anesthesiology, the quality of medical care resulting is often inferior; and attempts by physicians to raise the quality of medical care in these hospitals are seldom successful.

Sincerely,

J. RUSSELL GOOD, M.D., *Secretary.*

STATE OF ILLINOIS,
DEPARTMENT OF PUBLIC HEALTH,
Springfield, May 7, 1965.

Hon. HARRY FLOOD BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: With appreciation to Senator Douglas upon whose request I was invited to make written recommendations for your Committee on Finance, the following is suggested:

Since title XIX makes it possible for medical care elements of H.R. 6675 to be separately administered, it is recommended that the legislation be modified in order to facilitate assignment of responsibility to State health departments working in cooperation with the State welfare agency. The principle of medical care administration in a health agency will increase the benefits to the patient and insure interdepartmental cooperation in tax-supported medical care programs.

Yours sincerely,

FRANKLIN D. YODER, M.D.,
Director of Public Health.

SOCIAL SECURITY AMENDMENTS OF 1965 (H.R. 6675)—A STATEMENT BY THE NATIONAL CONFERENCE OF STATE SOCIAL SECURITY ADMINISTRATORS, SUBMITTED BY MISS EDNA M. REEVES, CHAIRMAN, LEGISLATIVE COMMITTEE, MONTGOMERY, ALA.

Under section 218(c)(5) of the Social Security Act, relating to coverage of employees of State and local governments under social security, the individual States are allowed the option of electing to exclude services performed by students, including student interns.

A number of States, with respect to State employees who are interns in State hospitals and institutions, and on behalf of local governmental entities, have elected such an exclusion, in good faith and relying on the good faith of the Federal Government to honor such an exclusion in the mutual agreements executed between the States and the Federal Government pursuant to section 218 of the Social Security Act.

It is our understanding that the provisions of section 311(a)(4) of H.R. 6675 could have the effect of nullifying the exclusion of student intern services already obtained by the States and their political subdivisions pursuant to section 218(c)(5) of the Social Security Act.

We believe this to be an oversight; and if not, then a grave injustice is being imposed on State and local governmental entities; and it is further believed that the Congress desires to honor the provisions of agreements previously entered into between the States and the Federal Government. Therefore, we respectfully request that the following sentence or similar language be added to section 311(c) of H.R. 6675:

"Notwithstanding the provisions of paragraph (4) of subsection (a), where services of interns have been excluded from coverage under title II pursuant to section 218(c)(5) of the Social Security Act under agreements, or modifications thereof, entered into between the Secretary and the States pursuant to section 218 of the Social Security Act prior to July 1, 1965, such services shall continue to be excluded unless coverage is extended pursuant to section 218(c)(4) of the Social Security Act."

We wish to emphasize the intent of this request is strictly to retain the exclusion of services previously excluded and in no way relates to the overall intent of section 311 of the bill to cover services of doctors of medicine and interns generally, on which subject we have not taken position.

OHIO SOCIETY OF ANESTHESIOLOGISTS, INC.,
Garfield Heights, Ohio, May 6, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: As president of the Ohio Society of Anesthesiologists, I write to solicit your committee's support in treating anesthesiology in the same manner as other medical services in the so-called medicare legislation, H.R. 6675, which is now pending before the Senate and under consideration by your committee.

I am also director of the department of anesthesiology at Marymount Hospital, in Cleveland, Ohio. I am in charge of a residency training program in this specialty and I practice independently. In other words, I am in the private practice of anesthesiology.

I have been quite active in the past decade in various official positions with the Ohio Society of Anesthesiologists, and have watched it grow from a neophyte, with a few members, to 20 times its original membership. It has been quite a struggle over the years for us to be able to not only encourage our members, but also our opponents that we should practice independently. At the present time, 97 percent of our membership are in private practice. Due to the fact that we have encouraged the private practice of our speciality, we have been able to influence many of the younger physicians to enter our specialty.

The committee must realize that by this mode of practice, a patient-physician relation develops to the point that many times patients will request the services of a specific anesthesiologist. This is evidence that we develop a practice in the same manner as our colleagues in medicine.

Most insurance carriers have recognized this fact and have made allowances for anesthesiologists' services in medical service contracts.

For the above-mentioned reasons, anesthesiology must not be included in the bill as a hospital service. To do so, would result in a regression in the future of our specialty.

Respectfully submitted.

NICHOLAS G. DEPIERO, M.D.,
President.

THE WEST VIRGINIA RADIOLOGICAL SOCIETY,
May 8, 1965.

Senator HARRY BYRD,
Chairman, Senate Finance Committee,
U.S. Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: The services of pathologists, radiologists, physiatrists, and anesthesiologists are professional medical services performed by physicians. The fact that their practice is largely in the hospital is incidental. These are not hospital services, and they do not belong in a program designed solely to offer hospital benefits.

As it stands, H.R. 6675 excludes from inpatient hospital services the services of pathologists, radiologists, physiatrists, and anesthesiologists. In any bill which is considered by the Senate, it is strongly urged that section 1861, subsection (B), page 63, be retained without modification.

Approval of H.R. 6675 as now written would tend to lower the cost of medical care. Over the past 25 years, hospital costs have increased 405 percent, while physicians' fees have gone up only 100 percent compared to an overall increase

in the cost of living of 115 percent. If physicians' fees in the four specialties cited above are stated separately from hospital charges, the cost of these services to patients will be reduced and hospitals will not be able to justify profits they are now realizing, particularly in pathology and radiology, if their charges are stated separately from the physician's fee. Combining the hospital charge with the doctor's fee as would be required if the Douglas amendment was approved, would obscure and hide the hospital profit in these departments.

Any measure which taxes the sick to subsidize other patients or functions of a hospital operation without the patient's full knowledge is unjust.

I would hope that the above comments indicate to you why no physician's services should be encompassed by the proposed "medicare" bill. There are many additional reasons which cannot be incorporated in this communication with which you are probably already familiar.

In the best interest of continued high-quality patient care and in all justice to those assuming responsibility of patients' hospital bills, we respectfully urge that no measure even remotely resembling H.R. 6675 be enacted into law which includes any physician's services.

Respectfully yours,

JOSEPH L. CURRY, M.D., *President.*

MAINE MEDICAL CENTER,
Portland, Maine, May 5, 1965.

Senator HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: We, the undersigned, respectfully and urgently request your support with regard to H.R. 6675.

Efforts are being made to change this bill, as passed by the House of Representatives, so as to include within its section 1 the services of physicians who specialize in radiology, pathology, anesthesiology, and physical medicine.

We feel that it is not the aim of the proponents of this legislation to interfere with the practice of medicine insofar as the patient-doctor relationship is concerned. Physicians in these specialties are an integral part of the practice of medicine in the same category as are those physicians who practice surgery, internal medicine, or any other designated field of medicine.

The inclusion of the services of these or any other physicians under a hospital care program would have an undesirable effect upon the present and future availability of these vital specialists. If beneficiaries of H.R. 6675 were to be concentrated in hospital departments, there would result a poor overall usage of existing office facilities and a tremendous overload on hospital departments of radiology, pathology, etc. Such an inclusion would also increase the anticipated costs of providing these medical services by an overwhelming amount.

Most importantly, the overall implications of including the services of these physicians under a hospital care program would be to unwisely restrict the freedom of choice of both patients and physicians in utilizing the necessary services of these four specialty groups.

Despite all the facilities and superstructure of modern medical care, there is no substitute for the aggressive independence and sense of responsibility, which a good doctor must have in order to place the best interests of his patient ahead of any other consideration.

Yours sincerely,

JOHN F. GIBBONS, M.D.
IRVING L. SELVAGE, M.D.
CHARLES W. CAPRON, M.D.
ROBERT A. BEAROR, M.D.

PLEASANT HILL, CALIF., *May 5, 1965.*

Senator HARRY BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I would like to compliment you on your decision to hold public hearings on the Mills bill. Since no public hearings were held in the House these hearings now in the Senate Finance Committee stand as further evidence of the openmindedness of its chairman.

I would like to register my opposition to the Mills bill. Since I have been speaking frequently to interested groups in this area about medicare, I had my arguments printed and I am enclosing a copy of the same for your perusal and consideration at this time. The most pertinent arguments begin on page 5.

I would also like to register my opposition to compulsory inclusion of physicians into the social security as is provided for in H.R. 6675. I feel I could invest my own money more wisely and retain better control than under the social security system.

Thank you for your consideration of these views.

Sincerely,

JOHN P. TOTH, M.D.

MEDICAL CARE FOR THE AGED

(By John Toth, M.D.)

The entire concept of medical care for the aged has been lost in a sea of emotional confusion. Anyone who is against governmental compulsory aid to the aged is automatically equated as being against the old folks themselves. You may have seen the postcards circulated by COPE the last time medicare came before the legislature (spring 1964), showing an old woman bent over, with a cane in her hand and a pleading look on her face, the caption reading "Do not forsake me in my old age." I'd like today to paint a picture of medical care for the aged in its true perspective. I will attempt to show the true scope of the problem, the available existing solutions to the problem, and the new proposed solutions to the problems. These proposed solutions are many, but I will concentrate on medicare and eldercare.

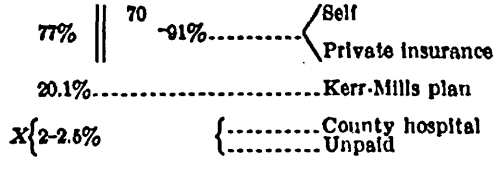
THE SCOPE OF THE PROBLEM

An estimated 18 million Americans are over the age of 65.[1] Many Government sources would have you believe that the great majority are practically destitute and although able to meet most of their daily needs, must have some financial assistance now to help finance a medical emergency. Let's look at the statistics a little more critically:

Income range:	*Percent of over 65 in that range*[1]
Over 6,000	25.3
5 to 6,000	7.9
4 to 5,000	8.9
3 to 4,000	12.8
Under 3,000	45.1

Average net worth:[3]	*Age group*
30,718	65 and over.
25,459	45 to 54.
19,442	35 to 44.

Over 65 health care expenses and how paid[4,5]



True enough, the average income of persons over 65 is less than the average income of persons at the peak of their productive careers, but neither does the older man have the expenses of the younger man—his home is usually paid for (80 percent own their own home,[6] 70 percent of these are mortgage free), his children have been raised and educated, and he has only to provide for his daily needs, recreation, and possibly medical insurance. So comparing his income/expense ratio you will probably find him much better off than looking at his income alone would indicate.

For reference figures, see bibliography at end of article on page 1169.

AVAILABLE SOLUTIONS

Referring to (X) above under health care expenses, you will note that it is this element of the older folks' problem to which an emotional appeal is made for legislation. (Note later that the proposed medicare would nonetheless include all of the older folks, even those who have proven their ability to provide for themselves.) So let's approach this problem from the standpoint of a person over 65 who actually has tried his best to save and care for himself, but due to unforeseen and uncontrollable events finds himself without funds and in need of medical care. This is the person to whom our sympathies are extended. Where can he go for help?

(1) Doctor's private office: According to figures on page 76 of the March 1965 issue of "Physician's Management" magazine, American private physicians forgive $760 million in fees annually. In addition, many free samples of medication are dispensed that have been made available by drug salesmen.

(2) Private insurance: If this person has insurance either through his own efforts or through his previous employer or union, this will help to defray medical expenses. National statistics show that about 60 percent of persons over 65 are covered by health and accident insurance. In addition, the "Western 65" plans are gaining wide acceptance, where lower rates are offered to older people, which is made possible by many large insurance companies pooling the risk.

(3) County hospitals: These are usually run as charity hospitals, or provide a a means test with an escalating percentage being paid by the patient, depending on his income. I am now going to speak in favor of a tax-supported county hospital, and later I will denounce any medical care supported by a compulsory Federal tax and run by the Federal Government. I'd like to show that this is not as contradictory as it would at first seem.

(*a*) In a federally controlled tax-supported medical care system, only the elderly recipients would benefit, whereas on a county hospital basis, the entire community benefits:

(i) County hospitals provide training for young doctors, and as such attract young doctors to the communities supporting the county hospital.

(ii) Frequently the county hospitals, being large and being training centers, have equipment that is considered experimental, such as the heart-lung machine, the artificial kidney, etc., that are rare and life-saving, and these otherwise might not be available to residents of the community who might suddenly need them.

(*b*) A federally controlled compulsory tax medical care system can be expanded into socialized medicine throughout the country. This is not so on a county, or even a State, level.

(*c*) A county hospital can be closed down or at least revised by the county board of supervisors, if its funds are mismanaged. No such restrictions are possible in a compulsory Federal situation such as medicare.

These are the basic means of caring for indigent and near indigent patients that have stood the test of time. Under the above systems, Federal intervention has been successfully restrained for over 30 years, because under this system not one individual in the entire United States could be found who was actually in need of medical care and could not get it. But the pressure for Federal "help" kept mounting until finally the Kerr-Mills bill was passed in 1960.

(4) County-State medical care system—Kerr-Mills: MAA (medical aid to the aged): This is a system of medical care supported by State, county, and Federal funds on a matching basis, and administered by the State and county, usually through the State welfare departments and the county hospital systems. Under this plan, a person may have up to $1,200 in cash ($2,400 per couple) and $5,000 real property, and an income which does not much exceed his cost of living to qualify for complete medical care. He must pay the first 30 days of hospital or nursing home care in California, but otherwise all diagnostic tests, medications, doctors' fees, hospital fees, and operations are covered completely at no further cost to the patient.[7] Repeal of this 30-day limit is now under consideration by the California Legislature.[8]

(5) Federal programs—Medicare: This bill has not yet been completely drawn up, but it is expected to follow the same general plan as the Gore amendment to the social security bill which was passed in the Senate in the fall of 1964. Almost every politically knowledgeable reporter predicts that passage of such a medicare bill is almost politically inevitable this year.

This is a system of medical care for the elderly supported by a compulsory Federal tax on all employees, either as an increase in social security taxes or as a separate payroll tax. This plan would provide:[9]

(*a*) Limited hospital care:

(i) Up to 45 days in hospital if patient pays nothing.

(ii) Up to 90 days in hospital if you pay $10 per day for first 9 days.

(iii) Up to 180 days in hospital after a deduction of 2½ times the average cost of 1 day's stay in the hospital

Specifically excluded are medical or surgical services provided by a physician, resident, or intern except in the fields of radiology, pathology, psychiatry, or anesthesia.

from a hospital and then is allowable only in a hospital-affiliated nursing

(*b*) Limited nursing home care: A maximum of 60 days after discharge from a hospital and then is allowable only in a hospital-affiliated nursing home, of which there are only 1,500 in the entire country (out of 25,000 nursing homes).[10]

(*c*) Limited outpatient diagnostic tests: Tests will be covered during any 30-day period after an initial $20.

(*d*) Home health services by a visiting nurse for a maximum of 240 visits per calendar year.

Even though this program cannot compare with the advantages of Kerr-Mills, it is still being pushed hard in the Legislature this year. The only possible explanation is the desire of Federal bureaucrats to control the program and ultimately to expand it to engulf the entire Nation in socialized medicine. I can think of no advantages to this program, but many disadvantages are evident:

(*a*) It is open to abuse. The system is being sold on the basis of the needy elderly. Why then should all persons over 65, even the wealthy, come under its provisions just because they are 65? This is unjust to the younger worker already heavily overburdened by taxes.

(*b*) It could easily be expanded by fiat to include other groups, such as widows, orphans, unwed mothers, underprivileged, etc., all with the same kind of logic (if some need it, give it to them all). Then, as the costs rise for each expansion, the wage earner being taxed $10, $15, or $20 per month would become impatient and want some benefits now, and eventually he and all of us will be included, and socialized medicine will have arrived.

(*c*) It is not insurance. No contract is given to the taxpayer, and the benefits are not guaranteed. Both the costs and the benefits may be changed by fiat. The fiscal solidarity is not governed by insurance laws. The money collected is redistributed, not invested as with an insurance company.

(*d*) Its costs have been grossly underestimated. Estimates of the cost for the first year alone range from $1.7 billion to $4 billion, and it would still provide less than 25 percent of the costs of medical care for the aged. Dr. Barkev Sanders, medical and welfare statistician for the Government for 30 years, reported in Nation's Business that the costs of the first year alone would be at least three and probably four times the presently estimated costs.[11] Since a doctor must certify when hospitalization was necessary, it is entirely possible that "overutilization by the doctors" would be the explanation given for the high costs. U.S. News & World Report stated that if the United States instituted a program of medical care such as exists in Canada now, the cost would be $62 billion per year, or about two-thirds of the present Federal budget.[12]

(*e*) It would subvert the existing voluntary health insurance plans. Over 60 percent of the elderly are now covered by some health insurance.[13]

(*f*) If this does lead to socialized medicine, the development of new drugs would be severely hampered. About 90 percent of all the drugs I prescribe today have been developed in the past 10–15 years, often at great expense to the companies. Pfizer spent $63 million developing terramycin about 10–15 years ago, and this drug is continuing to save thousands of lives. All existing government-run programs (VA, MAA, county systems, and military service) have established a formulary of standard drugs. Instead of buying five or six tetracycline drugs, for instance, they would settle on one and buy it in carload quantity to save money, and this drug only would get into the formulary.

What drug company could possibly afford to spend such a large sum of money, if the Government has the only market, and might keep it off the formulary of approved drugs?

WHY ARE DOCTORS AGAINST MEDICARE?

Once Federal Government control of a compulsory tax-supported medical care program is established, it will unquestionably be expanded as explained above. The proponents of medicare have stated this openly. Since the Government cannot supply taxpayers with medical care—only doctors can do that—the Government must control the doctors to fulfill its contract. This means that doctors will either be under the direct control of the Government or that doctors would be able to seek payment for their services from only one source—the Federal Government, and the Government could pay doctors whatever it wished. This has already occurred in all the other countries which have socialized medicine. What union leader or Government official would openly advocate that the Teamsters be paid only by the Government at a salary or wages determined by the Government? Yet this is what these same union leaders and Government officials demand of doctors when they call for legislation such as medicare. They are saying, in effect, that it is just and proper for semiskilled labor to bargain for their wages, but that the doctors who have a much more difficult, responsible, and exacting job, do not have the right to bargain for their wages on the open market. In April 1965, you will see probably 23,000 British doctors quit the British health plan and reenter private practice. Where does this leave the people who paid the taxes for this care that the Government now cannot deliver? The bigger question is, Why was the Government given this power in the first place?

The second reason doctors are against medicare is that the doctor is placed in a position of conflict—he is appointed unwillingly as guardian to the Treasury to ration's the scheme's benefits. On the one hand he must trust each patient to tell the truth about his ailments, but on the other hand must also mistrust and suspect each patient if he is to protect the solvency of the scheme.

(6) Federal programs—Eldercare: No Federal program is really necessary, but if a program must be passed let us pass one that will have as few disadvantages as possible. The eldercare program was promulgated by the AMA in response to the Federal medicare program, and is intended to replace it, not postpone it. Under this program, the existing State-Federal funds presently allowed under Kerr-Mills could be used to subsidize health insurance plans for low-income persons over 65 (Herlong-Curtis bill).[14] The program would be administered by the State health departments, not by the welfare departments. Premiums would be subsidized on an ability to pay basis.

Its relative advantages are these:

(*a*) It would operate on an insurance principle, where money paid to the insurance companies is invested, and the products of this investment will help to defray the costs of the program;

(*b*) Recipients would get an insurance contract which would guarantee and spell out their benefits;

(*c*) Would be cheaper because:

(i) It would utilize existing personnel and equipment in the health insurance industry,

(ii) Taxes would be used only for the needy;

(*d*) Fiscal solvency would be assured, as this would be subject to insurance laws;

(*e*) It would not be compulsory; and

(*f*) It would probably be much more difficult to expand into a system of total socialized medicine than medicare, unless these taxes come from social security or payroll taxes or are especially denoted as being for medical care for the aged, thus enabling the taxpayer to see just how much he's paying for this. (See Disadvantages to medicare (b).)

PHILOSOPHIC CONCEPTS

Over the years various forms of medical assistance have arisen and others will unquestionably arise in the future. I would like to leave with you some basic philosophic concepts which may help to guide your thinking along clear logical lines, not only for the present, but also for the future.

CONCEPT OF CHARITY

Charity is held high as a Judeo-Christian virtue. For a man voluntarily to give $10 a month to his favorite needy organization is a laudable thing. For the Government to take $10 from him against his will and give it to the same organization is detestible. The philosophic point here is this: The right of charity resides with the givers of charity, not with the receivers. If the recipients of charity have the right to receive it, then those providing the charity are obligated to give it to them, and it is no longer charity. So if the older folks' need for charity or for medical care becomes a right to charity or medical care, how did they get that right? And why just the older folks, etc.? In our concern over being charitable to those that need it, let's not ignore the just concern of those providing the charity.

CONCEPT OF TAXING ALL FOR THE BENEFIT OF A FEW

That this really means is this:

(*a*) That the Government can take $5 from you and $5 from me, and out of that $10 keep $4 for operating expenses, and contribute more to the total economy with that $6 than we could have with our $10.

(*b*) That the $5 you were going to give to your old college, and the $5 I was going to give to my old medical school are not legitimate uses for that money, that the only legitimate need for that $10 is the health care for those over 65. Then, of course, the Government will point to our old colleges, and since the grads cannot support it any longer, the Government says it needs governmental support and the whole process starts all over again, each time with a different need in sight.

The philosophic considerations are:

(i) Whose need is really the more important?

(ii) Whose right is it to decide? And by what standards? Where does it all stop?

The process never stops until we are all entangled in a bureaucracy that does not allow us to spend our money the way we like because it has taken it all away on taxation. The only way we can let them get away with this is by looking at each program independently, and then agreeing to it without regard to the total picture. It is not the right of Government "to provide for those who cannot provide for themselves," nor does a need for this exist. Present-day charities would adequately take care of this provided the Government doesn't tax away all the dollars we would otherwise give for charity.

THE CONCEPT THAT EVERYONE HAS A RIGHT TO MEDICAL CARE

Let's examine what this means—does this mean that everyone—or anyone—has the right to the products of another man's labor? This is exactly what it means. Who would have this right? To the products of whose labors? Why? By what standards? Compare the right to medical care to the right to go to a store and buy a can of peaches. If the Government made it economically unfeasible for all companies producing canned peaches to continue doing so, would you still have the right to buy a can of peaches. This is not a right, but a privilege. Ask any refugee from Castro's Cuba about that. I'm trying to say that to continue to have quality medical care you had best consider the source of the medical care; i.e., the doctor.

THE CONCEPT OF A MEANS TEST, AND QUALMS ABOUT IT

If a person is destitute and needs care, he will accept charity and be grateful. He will also accept a means test graciously as a matter of justice. If someone is trying to get something for nothing, he will fear a means test discovering this fact. So to whom is a means test degrading?

THE CONCEPT THAT "I CAN'T AFFORD IT, BUT I DON'T WANT CHARITY"

There are only two ways in which a man can receive money—either he earns it or he doesn't. (Please note that insurance and inheritance can properly be classified under earnings—insurance, because the man by his own effort has provided for the eventuality which the insurance covers, and inheritance be-

cause it was earned by his parents or ancestors and there is no one else to whom that money more rightfully belongs.) If he earns the money, it is his by right (in justice); if he does not earn it, only two ways of obtaining it are possible—either by charity or by force—from someone else who has earned it. There are no other alternatives. Those who would say that they want to receive money, or benefits, or services which they have not earned but say they do not want charity, are actually saying that they want to receive these things from someone else by force (usually by governmental force; i.e., taxation of those who have earned their money). By what right can anyone hold this view?

CONCLUSION

Private medicine in the United States has created the best system of medical care in the world. It has built doctors of courage and vision who by their individual efforts have advanced medicine and led the way to better care for all the people. This has occurred because doctors are free to pursue their careers as they know best, not dictated by Federal bureaucrats.

Over the past 30 years the Government has expanded more and more into control over our individual decisions, and has taxed us heavily to support its control. Many of these programs are not authorized by the Constitution and hence are unconstitutional, including medicare in any form. The ultimate solution is for the people to find and elect to the Congress and to the Presidency men who understand and respect the Constitution and will therefore eliminate all Federal activity in the field of private medicine.

However, for the present we can hold off socialized medicine if each of you would write to your Congressman expressing your opposition to medicare and support for the eldercare program. Do it today. It's your health that's at stake, and your money, and perhaps your life.

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[5] Reader's Digest, February 1965, "Medicare or Medical Care," by Walter Judd, M.D.
[6] University of Michigan Survey Research Center.
[7] Refer to department of social welfare, State of California.
[8] Assembly bill 760/1965, by Assemblyman Jack Casey, of Bakersfield.
[9] Ibid., 5 above.
[10] The Washington News, Jan. 27, 1965.
[11] Ibid., 5 above. Also Nation's Business, November 1964.
[12] U.S. News & World Report, Oct. 5, 1964, p. 68.
[13] Ibid., 5 above.
[14] H.R. 4727, "The Eldercare Act of 1965," introduced by Herlong and Curtis.

NOTE.—The philosophic concepts are basically libertarian and reflect my personal convictions.

STATEMENT OF THE CATHOLIC HOSPITAL ASSOCIATION CONCERNING AMENDMENT OF H.R. 6675

The Catholic Hospital Association of the United States and Canada strongly supports the position of the American Hospital Association in recommending that H.R. 6675 be amended appropriately wherever necessary to provide that the cost of the hospital services of radiologists, pathologists, anesthesiologists, and physiatrists are reimbursable under the basic hospitalization plan.

The exclusion of the services provided in the field of radiology, pathology, anesthesiology and physiatry from the benefits of the hospitalization will penalize the very group which this legislation is designed to benefit, and will furthermore eventually affect existing patterns of payment for patient care for all who require hospital care since it will be impractical for hospitals to provide diagnostic and treatment facilities to be reimbursed under two systems of accounting.

The 860 general hospitals and some 300 nursing homes in the Catholic system of health care will be most grateful and appreciative for any efforts that can be made to include the above-mentioned specialty services in the proposed legislation.

Respectfully submitted for the Catholic Hospital Association of the United States and Canada.

VERY REV. MSGR. JAMES H. FITZPATRICK,
President.

REV. JOHN J. FLANAGAN, S.J.,
Executive Director.

STATEMENT BY CONGRESSMAN D. R. (BILLY) MATTHEWS, EIGHTH DISTRICT OF FLORIDA

Mr. Chairman, I appreciate this opportunity to testify on behalf of my bill, H.R. 7070, a bill to amend the Social Security Act.

This bill is similar to H.R. 2465, introduced by the Honorable Claude Pepper, of Florida, and it is my understanding that it is also identical legislation to S. 112; which has been introduced by Senator Vance Hartke. It is my understanding that Senator Hartke has indicated that he will offer his bill, S. 1125, as an amendment to the House-passed bill, H.R. 6675. I want to associate myself with the views of Senator Hartke in this connection.

Mr. Chairman, my bill, H.R. 7070, and the others I have mentioned, if enacted into law, would be an important step forward in helping our senior citizens throughout this great country to obtain much needed help and care that they deserve. This bill would permit a widow who married again to retain her social security benefits even though her new spouse's benefits would entitle her to less money. There are many aged couples who live together without benefit of clergy because they simply cannot afford to lose the widow's cash benefits. What they get now is about $80 a month at most for a widow and many of them are getting the average amount which is only $67.85 monthly.

The passage of this bill would mean that they would be able to obtain $20 to $30 a month, and the Social Security Administration has advised that the cost of the change to this system should be negligible. I think this bill is an important step in easing the very dire circumstances of many older Americans.

Thank you for permitting me this opportunity to present this testimony.

AMERICAN MUTUAL INSURANCE ALLIANCE,
Chicago, Ill., May 7, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The American Mutual Insurance Alliance is deeply concerned about the harmful implications of section 303 of H.R. 6675, which changes the definition of disability in the Social Security Act. The alliance represents more than 100 insurance companies, including some of the Nation's largest writers of workmen's compensation insurance. Together, they write approximately 25 percent of all such insurance written by private carriers in this country.

I appeal to you on their behalf, and ask that this letter stating their position be made part of the official testimony. But I also appeal to you out of my own personal concern for the survival of the State workmen's compensation system. I have been intimately associated with the system as workmen's compensation commissioner of the State of Kansas and at the alliance. I have seen firsthand what the system has accomplished and how it has evolved to keep pace with the the changing needs of our society. I believe sincerely that workmen's compensation should be considered the primary system for compensating job-related disabilities. It should not be undermined by expansion of the social security disability program.

The genius of workmen's compensation is that it gives everyone concerned a financial incentive to live up to their humanitarian impulses. Employers have a financial incentive to maintain safe working conditions and to take steps that will minimize employee injuries. This incentive is built-in, since the system is based on the principle that the cost of employee injuries is part of the cost of production. Workmen's compensation insurance rates are based on actual loss experience, which gives safety easily measured dollars-and-cents value and makes it part of the competitive, business-enterprise system. Employers also have a financial incentive to see that injured employees obtain proper medical care and rehabilitation services. The objective is to restore the disabled to health and return him as quickly as possible to gainful employment. The quicker this is done, the less expensive it will be for the employer and employee alike.

The injured employee likewise has an incentive to get well and return to work under workmen's compensation. Most States now provide for unlimited medical services, including rehabilitation, so that he need not forego treatment for lack of funds. Wage-replacement benefits also are provided, and they are flexible so that the worker who returns at a lower salary because of partial impairment can continue to receive supplementary benefits.

Social security, on the other hand, is strictly a pay-in, pay-out system. It deals solely with the financial effect of disability and does nothing whatever to prevent disability from occurring. It is an inflexible system which by its very nature finds it difficult to handle the job of rehabilitating those in its care. In testimony before this committee, the Social Security Administration has sought to explain why only 7 percent of its disability recipients have received even the most rudimentary kind of rehabilitation services. The agency has tried to create the impression that the figure is so low because the people on the rolls are all severely disabled. But a report in the June 1963 issue of the Social Security Bulletin cites a less comforting reason: "One reason that so few of the disabled persons received rehabilitation services seems to have been that few of them were aware of the existence of such facilities."

The report added that a survey showed almost 9 out of 10 workers who had not received rehabilitation services "had not known of such facilities." Apparently social security, in its management, is inherently incapable of bringing together the needed disciplines to provide successful rehabilitation techniques. The point is, rehabilitating a severely disabled person is a delicate process, requiring skilled personnel and coordination of the efforts of all persons and agencies involved: the employer, the medical specialists, the injured person's family, and the agency supplying the funds. Social security, being primarily an agency set up to issue monthly checks, is simply not organized nor staffed to initiate and carry through the intricate process of rehabilitation. Workmen's compensation insurers are equiped to do the job, and have been doing so successfully for many years.

There is a real and serious danger that the incentives built into the state workmen's compensation system, and the expertise provided by private carriers, will be shouldered aside if social security continues to encroach on the system. I use the word "enroach" advisedly, because that is exactly what is happening. Prior to 1958, the social security disability program recognized workmen's compensation as the primary system in the field of occupational disability. Federal disability benefits were offset to the extent that a recipient already was being compensated under workmen's compensation. This offset was removed in 1958, thereby creating a problem of overlapping benefits and putting social security on a collision course with workmen's compensation.

Social security spokesmen have testified that the overlap is so small as to be insignificant. They repeatedly mentioned the figure of 2 percent. But this 2 percent figure was based on a limited study made in 1960, before the age limit of 50 was dropped. Even that limited survey ("The Disabled Worker Under OASI," HEW Research Report No. 6) indicated that workmen's compensation cases were at least twice as numerous among persons below age 50, based on the number who had applied to social security for a wage freeze. Moreover, it is recognized that there has been a substantial judicial broadening of the definition of disability since that 1960 study was made. It would appear that the overlap today could well be considerably higher than 2 percent. In a speech to the Southern Association of Industrial Commissioners in Dallas, Mr. Victor Cristgau, director of OASDI, said the Social Security Administration recognized that the duplication of benefits was in excess of what they had originally thought. All of this points to the need for determining the nature, the extent, and ultimate impact of the overlap on the State workmen's compensation system. Yet in section 303 we have a proposal that would greatly increase the duplication by broadening the definition of disability. It would do so by radically changing the nature of the whole disability program, which until now has been considered a form of retirement benefit for workers who have been prematurely retired because of long-term disability. Section 303 would eliminate the eligibility requirement that a disability be expected to result in death or to be of "long-continued and indefinite duration." Instead, it would require only that the disabled person be off work for 6 months in order to be eligible for social security disability benefits.

This would add to the rolls thousands of workers with temporary, short-term disabilities, even though many of them already are receiving workmen's compensation. The result is that these employees will be able to collect more income, tax-free, for remaining at home than they were earning on the job prior to their disability. What effect do you think this will have on efforts to rehabilitate injured employees and return them to work. What effect on employers, who will be paying twice for the same disability? And what effect on the future of the workmen's compensation system itself? Proponents of social

security have suggested that the way to cure the abuses created by the overlap is to offset workmen's compensation. This means that workmen's compensation adapts itself to social security. But if that is done, every future expansion of the social security system will mean an equal contraction of the workmen's compensation system. Such a concept will ultimately undermine the State system.

It is interesting to note that the problem of overlapping benefits was fully recognized in the medicare portion of H.R. 6675, in contrast with the disability amendment. Medicare benefits are offset where the recipient already is receiving workmen's compensation medical benefits. It is also interesting that both the House Ways and Means Committee and the Social Security Advisory Council have called for study of the harmful effects of the existing duplication of benefits. Ways and Means has ordered the Social Security Administration to make such a study and report back by 1966.

That being the case, it does not make sense to legislate still more duplication of benefits before the study is made and the facts are known. The alliance believes strongly that a thorough study of the overlap is in order, involving the State industrial commissions, State workmen's compensation commissions and the workmen's compensation carriers as well as the Social Security Administration. For our part, we pledge our full cooperation in carrying out such a study.

The alliance earnestly asks that section 303 be stricken from H.R. 6675 and considered on its merits. Its implications are important and farreaching. Congress already has asked for hard facts on this subject, and the groups affected have indicated their willingness to help supply the facts. It is only fair to wait until the evidence is in before making a decision of such overriding importance to the States, to employers, and to disabled workers.

Sincerely,

PAUL S. WISE, *General Manager.*

CONYERS, GA., *May 10, 1965.*

To: The Senate Finance Committee.
From: The American Council of the Blind.
Subject: H.R. 6675.

The American Council of the Blind submits the following statement and requests that it be included in the record of the committee hearings on the pending legislation.

We endorse the provision of medical benefits under title II of the Social Security Act and believe that such benefits should be extended to all beneficiaries.

We approve of the amendment presently contained in the bill changing the definition of disability but we believe there is a need for further amendment to provide a more objective standard. "Substantial gainful activity" has been construed differently in different parts of the country depending upon the personal judgment of the one making the determination. Some claimants whose claims for benefits have been denied have been declared in the determination to be able to do certain kinds of work. We believe that findings of ability and determination of eligibility should be directly related to the availability of such work and to the ability of governmental agencies to place the claimant in employment. If no employer will hire a disabled worker then the administrative finding becomes academic and arbitrary and the insured worker suffers the obvious consequences.

The American Council of the Blind believes that as long as benefits are inadequate to provide a decent minimum standard of living the earned income provisions of the law should be liberalized to permit the supplementation of income through the beneficiary's individual efforts. Likewise we oppose in principle the reduction of benefits because one is also entitled to benefits from certain other sources. The means test is not a proper part of an insurance program.

This organization is most seriously interested in the inclusion as an amendment to the pending bill of the provisions of S. 1787 which provides the usually accepted definition of blindness as an alternative standard of eligibility for benefits. Section 25 of S. 940 also contains the same provisions. The merits of these measures were effectively and adequately stated on the floor of the Senate by the Honorable Hubert H. Humphrey on September 3, 1964, when he successfully offered the same proposition as an amendment to the bill then pending. His

remarks are endorsed and incorporated here by reference. In effect, we seek insurance against the economic consequences of blindness. The great incidence of blindness in this country occurs after age 45 thereby combining obstacles to economic adjustment. Moreover, the history has been that blind workers have been rehabilitated in lower paying jobs than they previously held. Accordingly, even where some adjustment has been achieved there has been an economic loss to the individual. We recognize the ability of blind persons to adjust and to be productive workers. We also recognize the economic loss almost always incurred as a result of blindness. Most significantly, we recognize the difficulty in actually obtaining employment even where ability has not been impaired by blindness and combinations of other conditions including advancing age.

Since most persons lose their sight in middle age or old age most of them will have far more than six quarters of coverage provided for in S. 1787. However, this minimum will be a protection to those who lose their sight before they have had time to earn during a longer period of time.

We note with strong approval that S. 1787 has no restriction as to age or earnings. This is a realistic approach to a true insurance program which should have no penalizing restrictions which would offset its true purpose.

We here express our appreciation to the authors of S. 1787 and to Senator Tower for including these provisions in his bill.

The American Council of the Blind urges that the public assistance amendments contained in the pending bill be enlarged to prohibit States from imposing lien laws, relatives' responsibility and residence requirements upon recipients of assistance. Certainly as long as so much of the grants are provided by Federal funds such prohibitions are entirely proper at the Federal level. We deplore the continuation of a discriminatory matching formula in providing assistance for persons living in Puerto Rico, Guam, and the Virgin Islands. We believe that the Federal support should be the same as for residents of the several States.

We urge that social security benefits be required to be disregarded by the States in determining eligibility for assistance since such benefits are actually deferred payments of earned income and should be so defined.

THE AMERICAN COUNCIL OF THE BLIND,
By DURWARD K. MCDANIEL,
First Vice President.

WASHINGTON, D.C., *May 7, 1965.*

To Senator Harry F. Byrd, U.S. Senate.
Subject: OASDI tax of self-employed under H.R. 6675.

At the time of consideration of subject legislation, I kept pointing out to our Ways and Means Committee the very unfair tax that would be imposed on the self-employed wherein they will be paying 1½ times the tax paid by the employee for the same benefits. Some of the points which I raised are contained in the attached copy of a portion of my remarks when debate on this legislation was held on the House floor.

During committee discussion, I made several suggestions of alternatives in the approach to this problem, some of them in the form of amendments. These alternative suggestions were:

(1) Reduction of the 150-percent self-employed tax to 100 percent.

(2) Reduction of the 150-percent rate to 125 percent.

(3) Allowance of the extra 50 percent paid as an expense deduction for Federal income tax purposes.

(4) Reduction of the rate for self-employed to 100 percent if the taxpayer has less than three employees.

(5) That the rate be 100 percent if the self-employed has no regular full-time employee who works more than 6 months of the year. This provision would take care of the many farmers who hire seasonal workers for only several weeks' duration during crop harvest.

(6) That the rate be 100 percent if the adjusted gross income of the self-employed is less than $10,000 a year.

While many members of the committee felt that several of these proposals had merit, and warranted consideration, nevertheless none was adopted by the committee in the rush to hasten this legislation to the House floor for passage.

A perusal of the attached portion of my remarks should convince you that some consideration should be given to this large group of taxpayers who will

be subject to very inequitable treatment under the proposed legislation. I am hopeful that the Senate Finance Committee will take steps to correct this inequity.

Sincerely,

HERMAN T. SCHNEEBELI,
Member of Congress.

REMARKS OF HERMAN T. SCHNEEBELI

This extra tax on the self-employed becomes particularly onerous as the tax rates increase. Under this bill, a self-employed person whose earnings equal the tax base will over his productive years—age 21 to 65—have paid total social security—OASDI—taxes of $19,712 as compared with taxes of $13,467 paid on the same wage base by an employee. When compounded at 3½-percent interest—the rate used by the Department—the self-employed OASDI tax comes to $45,032 compared with $30,079 for the employee. Forty-five thousand dollars is a lot of money to a small farmer, a small shopkeeper, a member of the clergy, a barber, and the many millions of self-employed in our service industries.

This additional tax on the self-employed cannot be justified either by the benefits they receive or by their ability to pay. Benefits are the same both for the self-employed and the employee. In the payroll tax, ability to pay is completely disregarded. The president of a large corporation pays only two-thirds the tax of the self-employed barber—and we can be certain that there are more barbers, small shopkeepers, filling station operators, and the like, than there are affluent professional people among the self-employed.

Of the approximately 7 million taxpayers who file returns as self-employed, more than one-half report adjusted gross income of less than $5,000 per year. This is the group which pays 50-percent more in social security taxes than do the executives of our large corporations. They are the farmers, ministers, barbers, taxi owners, filling station operators, small grocers, newsstand operators, and the like. Many have no employees at all, other than occasional family or part-time help.

A minister in my district wrote:

"So far this year I have paid or owe $587 in taxes on my 1965 income (which is slightly over $4,800). This total figure for taxes includes $139 in local taxes, $189 in Federal income tax, and $259 in social security tax. The figure, of course, does not include the Pennsylvania sales tax and the various hidden taxes.

There are three children in our family (the youngest is 5 years of age and the oldest, 12 years of age). I find it extremely difficult at the present time to set aside one-eighth of my income to cover these various taxes. If the social security tax is increased, the payment of the increase will not only be extremely difficult, but it will become virtually impossible without depriving the five members of the family of adequate food, clothing, and dental and medical care. Doubtless many other clergymen and other persons classified as self-employed find themselves in the same predicament."

In rejecting my proposal that we take action in this bill to remove the penalty on the self-employed, I was told that it would cost too much. I am not impressed with the answer. Actually, the initial cost to adjust this tax would amount to 0.07 percent of payroll at a $5,600 base. With the projected increases in both the tax and wage base, which are provided in the bill, I am confident that the shifting of this extra burden—now paid by the self-employed—to all wage earners and employers, including the same self-employed, would not have a significant impact on the social security trust fund. And this impact could well be spread over a period of years, just as the committee bill spreads the cost of increased cash benefits and the cost of the hospitalization program.

The additional tax to finance the health insurance program provides the same rate for the employer, the employee, and the self-employed alike. If the principle of this new tax is right, there is no justification for continuing to tax the self-employed at a much higher rate to finance cash benefits.

I earnestly hope that the other body, on passage of the bill, will face up to this problem. The self-employed need help; and all I ask is that they be given the same consideration as everyone else.

ABBOTT LABORATORIES,
North Chicago, Ill., May 13, 1965.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Thank you for your letter of May 10, 1965, to Mr. George Cain and your invitation to submit a written statement of Abbott Laboratories' position on H.R. 6675. We also appreciate your offer to make our statement a part of the public record of the hearings.

As a major drug manufacturer, Abbottt Laboratories is a research minded organization. The purpose of pharmaceutical research is, of course, to find new and better weapons for the "health teams'" constant battle against the ravages of disease. The problem your committee is now facing stems, in large part, from the success of the "health teams'" efforts to extend the life of our people by conquering many of the diseases which a few years ago took so many people in the prime of life.

We cannot and do not feel, however, that the solution of the problem lies in depriving physicians of drugs which they have used for many years with demonstrated success, nor of new drugs which will be the result of millions of dollars and thousands of scientific man-hours expended, not only by Abbott, but by all of the research oriented companies.

H.R. 6675, unless appropriately amended, will encourage just such an unfortunate trend. For example, section 1861(t) which defines the terms "drugs" and "biologicals" would limit the reimbursement for drugs to only those products described in the U.S. Pharmacopoeia or the National Formulary, or in New Drugs, or Accepted Dental Remedies, or to those approved by a local hospital therapeutics committee.

The official compendia were never meant to be an exhaustive list of safe and effective drugs. Note that the preface to Pharmacopoeia of the United States, 16th revision, in discussing its function of selecting a list of drugs of established merit and necessity states on page XIV:

"Yet, by its nature, the process of selection can scarcely be perfect, for no means has been found to insure, at least by the time of publication, that all drugs included are of equal merit and that no others equally meritorious are omitted."

The National Formulary also lists drugs on the basis of therapeutic value. Neither volume purports to be complete and if, indeed, either were, it would be necessary to refer only to that one rather than to both.

New Drugs, the publication of the American Medical Association's Council on Drugs, according to the Journal of the American Medical Association, December 14, 1965, volume 190, No. 11, will not necessarily be recommending the drugs upon which it will be commenting. On page 112, the Journal of the American Medical Association says:

"It should be emphasized that 'New Drugs' is not a textbook on pharmacology or therapeutics; instead it deals with the safety and efficacy of new drugs and how they compare with other agents, both old and new, that have similar uses. Thus, the inclusion of a statement does not imply the council's acceptance or approval of the drug; the opinions are based on the weight of the available evidence, and may be either favorable or unfavorable."

And further: "The book presents the council's current evaluation of single-entity agents *that have been introduced within the past 10 years*—drugs that have reached the market since a majority of practicing physicians have completed their years of formal education and training." [Emphasis added.]

The inclusion of drugs approved by a local hospital therapeutics committee does not constitute a broadening of the number of drugs available to a physician sufficient to resolve the problem raised. It is generally known that such lists are too exclusionary to be acceptable in toto by the hospital staffs they are intended to serve. Weekly Pharmacy Reports, vol. 12, No. 19, of May 13, 1963, reporting on an agreement between the American Medical Association, the American Pharmaceutical Association, the American Hospital Association and the American Society of Hospital Pharmacists quotes the salient points of an accord on the proper function of hospital formularies, including the following:

"(4) Authorize the physician to prescribe medications not included in the formulary if in his judgment individual patients require special treatment.

"(5) Permit the physician, at the time of prescribing medications, to approve or disapprove the dispensing or the administration of medications in accordance with the hospital formulary system."

The criteria for selection of drugs for which reimbursement will be made is therefore inadequate. The compendia listed in the bill do not purport to be complete listings of drugs which have been found by the medical community to be useful and necessary in the proper practice of medicine. Neither do those persons most intimately associated with the operations of hospital drug therapeutics committees conceive of their efforts as being adequate to provide physicians with all drugs customarily used by their staffs.

We therefore ask that you accept the change in language recommended by Dr. Austin Smith on behalf of the Pharmaceutical Manufacturers' Association in his letter of April 12, 1965, which is addressed to you:

"It is our suggestion that section 1861(t) be amended by deleting the words: 'or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of a hospital furnishing such drugs and biologicals.' In lieu of this language insert the words: 'or are ordered or prescribed by the attending physicians on the medical staffs of hospitals for the care and treatment of patients'."

We further believe that sections 1814(b) and 1861(v)(1) give too broad powers to the Secretary of the Department of Health, Education, and Welfare in establishing what are reasonable costs. We suggest that the following language be added to the end of section 1861(v)(1):

"*Provided, however,* That charges for items or services furnished a patient shall be deemed to be reasonable if they are ordered or prescribed by the patient's physician for medical reasons, and if such charges do not exceed the customary amount charged by the provider of services to persons not subject to this title."

We endorse the position of the Pharmaceutical Manufacturers' Association, of which we are a member, as expressed by the testimony of Dr. Smith before your committee. The changes recommended are, we feel, essential to the broad purposes of the act.

Sincerely yours,

LAURENCE R. LEE,
Secretary and General Counsel.

NEW YORK CHAMBER OF COMMERCE,
New York, N.Y., May 11, 1965.

Re H.R. 6675.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: Your distinguished committee is studying a proposed hospital and medical care program for the aged so broad and far reaching in scope that one can only hazard a guess as to its ultimate consequences for our Nation. Whether for good or otherwise, it is certain that the elements of the program, once approved, will not easily be reversed. We deem it a matter of greatest urgency that the people and their representatives understand exactly what is at stake, and are confident that in your hands H.R. 6675 will receive the careful review it deserves.

Some aspects of this proposal the New York Chamber of Commerce must, in good conscience, oppose; others we support and urge approval by Congress. Thus, we endorse the general increase in current cash benefits, and we suggest further that a more liberal program of cash benefits may be the preferable answer to the problem of health and medical needs. At least this approach would avoid the actuarial quagmire posed by the concept of service benefits.

Our opposition to the proposed hospital and nursing home care program (in part A) centers in our belief that it is unwise to incorporate service benefits in a system whose fiscal integrity depends on the predictability of future obligations in relation to future revenues. This task is already sufficiently difficult, as can be seen in the repeated overly optimistic estimates of the trustees. Now we are preparing to accept unknowable costs—a step that violates social security principles and threatens the very foundation of the system. Nor is the setting up of a separate contingency reserve any real guarantee of protection; for a case in point note the proposed diversion of OASI revenues to cover deficits being incurred by the disability program.

The chamber's disagreement runs particularly strong as to the proposal to establish a voluntary medical insurance program subsidized from the general fund. It is not truly "voluntary" when the Government provides a 50-percent tax subsidy and estimates that up to 90–95 percent of the elderly will join. This proposal, which was not part of the administration's original bill and not subjected to the test, heretofore, of detailed public hearings is inconsistent with American social insurance theory and practice. Self-supporting people will be given an unnecessary subsidy; those on the borderline financially who are most in need of the benefits will have the greatest difficulty in putting up the money; but the improvident and impecunious will have their costs paid at the taxpayer's expense. Concerning the ultimate cost to the taxpayer, only experience will tell, though even the more conservative estimates are foreboding.

We feel strongly that general revenue financing of broad social programs is an error. A major discipline built into OASDI is the payroll tax device which reminds each worker that benefits cost money through commensurate increases in his contribution rates. This cost consciousness is lost when Government subsidies are made available from general revenues, and the sky literally becomes the limit of benefit levels. If Congress must enact a program of medical coverage, and this need, it seems to us, is questionable, it would be more desirable in our view to include it under OASDI where costs can be reflected in the payroll tax.

The supplementary program would put the Federal Government in the voluntary insurance business, and on a subsidized basis that would make it difficult for private carriers to compete. Moreover, it runs counter to the President's 1965 health message in which he urged a prominent place for health insurers in any supplemental plan—presumably as underwriters, not administrators. To a considerable degree it appears to have been added to the original measure without adequate consideration of all the implications. We recommend that it be rejected by the Senate.

Turning to those proposals which would affect the disability portion of social security, we wish to record our opposition to payment of benefits commencing with the sixth month of incapacity. Most private plans, especially group plans, already cover the sixth month and the resultant overlap of benefits would be undesirable. Further, this change is an unnecessary step into the realm of temporary disability insurance presently well served by private carriers.

Our final comments are made with reference to the proposed automatic increase in the earnings base to $6,600 in 1971. To schedule such an increase in advance is inconsistent with the wage-related character of social security. We have no guarantee that in 1971 average full-time earnings will amount to $6,600; if this proves true subsequently than Congress at that time can make the necessary adjustment. As it stands, this proposal is an attempt to use the wage base primarily as a revenue producing device—something the founders of the program never intended. In our view, there should not even be an ironclad rule to keep the base fixed at average wage levels; as society grows more affluent the relative role of social security should diminish with greater reliance placed on individual savings for the retirement years.

We respectfully request that these comments be made part of the official record of your hearings.

Sincerely yours,

MARK E. RICHARDSON,
Executive Vice President.

OLIN,
New York, N.Y., May 12, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee, U.S. Senate, Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: This letter is respectfully submitted in connection with H.R. 6675, 89th Congress, a bill establishing a new Federal hospital and related health care program which is now under active consideration by your committee.

E. R. Squibb & Sons, the pharmaceutical division of the Olin Mathieson Chemical Corp. has been engaged in the manufacture of medicinal products since 1858, is fundamentally interested in the research, production and distribution of medicinal products to the health professions, and has a deep concern for sound legislation affecting medical and other health services especially to our expanding population over 65.

We are very much pleased that your committee is extending well-deserved public discussion and consideration to the many aspects of the "medicare" legislation. We would like to submit our comments on several of the provisions of the proposed bill which we believe require further consideration and improvement:

(1) Our country leads the world in the development of health sciences. An amazing integrated network of education, research and progress in the development of medicinal products has reinforced the practice of medicine and the medical services which are provided throughout the country. Since most of these developments originate in private efforts, we are particularly pleased with the proposed language against Federal interference over the practice of medicine, over the manner in which medical services are provided, and over the administration of institutions and personnel. We commend particularly the patient's guarantee of free choice of any qualified agency or person as provided in section 1802 of the bill.

(2) We do, however, see a serious restriction in the language of section 1861(t) defining "drugs and biologicals," confining the selection of medicines only to those listed in certain named publications which excludes a high percentage of well-known extensively used medications not listed in these publications. Furthermore, we seriously question this interference with the attending physician's freedom of choice as to medication.

We recommend a modification of section 1861(t) by deleting the words, "or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of a hospital furnishing such drugs and biologicals," and substituting, "or are ordered or prescribed by the attending physicians on the medical staffs of hospitals for the care and treatment of patients."

Usually a considerable period of time must elapse before new drugs approved by FDA are officially listed in the U.S.P. and the other named publications. Yet their availability to prescribing physicians should be immediate on approval by FDA and should not be withheld from patients merely because of exclusion from a printed list.

The official publications also are incomplete in that many dosage forms of a widely used drug and combination product are not listed despite the widespread practice among physicians to use formulations they consider economical, convenient and effective for the treatment of their patients.

It has been called to our attention, for example, that 17 of the 50 most frequently prescribed drugs are not listed in the official compendia (U.S.P. or N.F.) nor in the N.N.D. or A.D.R., all of which are listed in this section of the bill. Of the 295 Squibb drugs presently used and dispensed in hospitals and pharmacies in this country, 128 or 43 percent are not included in any of the 4 above-identified publications.

This means that these drugs would be excluded from those available to attending physicians in the hospitals of the country unless they were listed among those drugs "approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals."

Under this restriction, aged participants of the benefits of this bill will be denied many drugs which their physicians customarily prescribe. The patients will be deprived of the best possible medicinal care and physicians will be restricted as to the medication they can choose for their patients. We understand that about half of the Nation's hospitals do not have therapeutic committees, and even where they do exist, many are reported to be relatively inactive and have a wide disparity in standards and procedures.

As a specific example, we provide several important combination drugs, particularly certain antibiotic products, which are widely used in the hospitals and private practice in this country including the treatment of conditions well known among the aged. Although each ingredient could be prescribed separately, economy, simplicity and practical therapy lead physicians to prefer to prescribe a combination product for desired effectiveness. Physicians should be free to prescribe for any person over 65 qualifying under the proposed bill, the same quality and choice of drug therapy that is available to that physician in the treatment of his other patients. They would be limited under the present provisions of H.R. 6075.

(3) We also hold grave reservations as to the interpretation which can be applied to the language of sections 1814(b) and 1861(v)(1). Both provisions

refer to the term, "reasonable cost" for these services and this introduces the requirement for the definition and interpretation of "reasonable cost." The language of the bill provides that regulations will be established as to the methods of determining costs for various types of institutions, agencies and services.

The Secretary by regulation, however, could exclude certain drugs on the basis of cost alone. The lowest price available to the Federal Government or State government as mass purchasers might well be a benchmark that would exclude due consideration of the distributing costs, marketing requirements, quality standards and research commitments of the industry. The primary issue should be the well-being of the patient, the professional decision of the attending physician and the effectiveness and quality characteristics of the medication—not where can medication be bought at the lowest price to handle welfare needs.

In order that physicians, hospitals and institutions, and the pharmaceutical industry retain freedom to conduct their operations in the best interests of the public, we propose that the following language be added at the end of section 1861(v)(1):

"*Provided, however*, That charges for items or services furnished a patient shall be deemed to be reasonable if they are ordered or prescribed by the patient's physician for medical reasons, and if such charges do not exceed the customary amount charged by the provider of services to persons not subject to this title."

It is our hope that you will give serious consideration to these comments and suggestions. We would also like to recommend in particular, favorable consideration of those comments presented by the Pharmaceutical Manufacturers Association in which we are an active member.

We fully recognize the importance and the forward progress implicit in the proposed legislation and we have every confidence that the hearings and the considerations provided by your committee will help tremendously in the fashioning of an improved bill that will meet the desires of the Congress in assistance to the aged.

Respectfully yours,

RICHARD M. FURLAUD.

PETERSBURG GENERAL HOSPITAL,
Petersburg, Va., May 12, 1965.

Hon. HARRY F. BYRD,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: This letter is in regards to H.R. 6675 which excludes the services of radiologists, pathologists, anesthesiologists, and psychiatrists as hospital benefits as it applies to medicare.

The Hospital Authority of the City of Petersburg went on record as opposing that portion of the bill and hereby asks your assistance to restore the services of these medical specialists as part of the hospital benefits.

With kindest regards, I am,

Sincerely,

GEORGE E. BOKINSKY, *Administrator.*

CONFERENCE OF STATE MANUFACTURERS ASSOCIATIONS,
Indianapolis, Ind., May 13, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
New Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: The Conference of State Manufacturers Associations would like to respectfully record its opposition to section 303(a) (1) and (2) of H.R. 6675 which would substantially increase the areas of duplication presently existing between State workmen's compensation programs and the disability program of the Social Security Act.

The enactment of the above section would definitively reduce major incentives for rehabilitation to injured workers and for the continued improvement of benefit levels by the States. Thus, the further expansion of Federal disability bene-

fits pyramiding, as it does, State workmen's compensation benefits, must inevitably lead to the abdication of serious State responsibilities and the probable ultimate extinction of State workmen's compensation programs.

We believe that our State workmen's compensation laws have now reached the point where they effectively fulfill the purposes for which they were enacted into law. Replacement by the social security disability program would tend to destroy the objectives which they seek to attain, without filling the open gap and resulting in detriment to the working population and the industrial community.

It is clear that the State workmen's compensation systems have attacked the very root of the necessity for their existence—the occurrence of accidents. No other social insurance program, including social security, can make a similar claim. Workmen's compensation has, in fact, helped to reduce the accident frequency in the past four decades by 80.6 percent and the severity rate by 72.2 percent. The cost of work injuries is through the rating system, borne directly by the employer under whose supervision injuries have occurred. This is the reason why in 1956 the U.S. Department of Labor, Bureau of Labor Standards reported that "workmen's compensation provided the first real stimulus to industrial accident prevention and is primarily responsible for the safety movement as we know it today.

"The fact that accidents are costly has been and still is the chief driving force behind the industrial safety work done in the field of industrial safety by insurance companies and by employers, both individually and through service organizations."

It was the need to restore losses brought about through industrial injuries which gave impetus to the development of the field of rehabilitation. Indeed, it is the business of the State workmen's compensation system to help injured men and women to return to their jobs. The control of disability through maximal restoration of a disabled person has become the goal of all State workmen's compensation laws. Savings resulting from properly administered rehabilitation programs are passed on to employers in the form of reduction of workmen's compensation premiums and rates. This built-in incentive encourages both employers and their insurance carriers to make maximum use of rehabilitation facilities in all possible cases.

Whether the State workmen's compensation system or the Federal social security system should have the basic responsibility for the administration of industrial accident indemnification depends upon what objectives are believed to be in the public interest. We recognize and are convinced that the State workmen's compensation system as it has evolved today represents a broader humanitarian approach than the disability program of the Social Security Act.

Respectfully,

A. C. CONDE, *Chairman.*

P.S.—Please see attached list of State manufacturing associations which have endorsed the foregoing statement.

The following state manufacturing associations have endorsed the foregoing statement:

Associated Industries of Alabama.
Associated Industries of Arkansas.
California Manufacturers Association.
Manufacturers Association of Colorado.
The Manufacturers Association of Connecticut, Inc.
Associated Industries of Florida.
Associated Industries of Georgia.
Hawaii Manufacturers Association.
Associated Industries of Idaho.
Illinois Manufacturers' Association.
Indiana Manufacturers Association.
Iowa Manufacturers Association.
Associated Industries of Kentucky.
Louisiana Manufacturers Association.
Associated Industries of Maine.
Michigan Manufacturers' Association.
Associated Industries of Massachusetts.
Minnesota Employers' Association.
Mississippi Manufacturers Association.

Associated Industries of Missouri.
Associated Industries of Nebraska.
New Hampshire Manufacturers Association.
New Jersey Manufacturers Association.
Associated Industries of New York.
The Ohio Manufacturers Association.
Associated Industries of Oklahoma, Inc.
Associated Oregon Industries, Inc.
Pennsylvania Manufacturers' Association.
Associated Industries of Puerto Rico.
Tennessee Manufacturers Association.
Texas Manufacturers Association.
Utah Manufacturers Association.
Associated Industries of Vermont.
Associated Industries of Washington.
West Virginia Manufacturers Association.
Wisconsin Manufacturers Association.
Virginia Manufacturers Association, Inc.

STATEMENT OF HON. ROBERT E. SWEENEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Chairman, I am very appreciative for the opportunity of appearing before your committee this morning to testify in support of the administration's Social Security Amendments of 1965. As a freshman Member of the 89th Congress, I was honored to support H.R. 6675 providing, as it does, a comprehensive hospital insurance program for the aged under social security.

I wish to pay particular compliment to the members of the House Committee on Ways and Means, and, in particular, to its distinguished chairman, the Honorable Wilbur D. Mills, of the great State of Arkansas. This committee worked long and diligently to establish a coordinated health insurance program for persons 65 or over.

As a candidate for the U.S. Congress, I pledge my support for the Johnson administration's basic plan for providing protection against the costs of hospital and related care, financed through a separate payroll tax and trust fund. But, in my view, this basic plan was broadly improved upon through the action of Chairman Mills and this committee by incorporating thereto a voluntary supplementary plan covering payments for physicians and other medical and health services. As a Member of the House of Representatives, I was proud of the work of the Committee on Ways and Means in reporting the bill to the floor, and I was honored to cast my vote in support of H.R. 6675.

I support the amendments providing for the two new insurance programs because I believe these amendments address themselves to the expanded medical care program for the needy and, in particular, the medically needy. The amendments to the Social Security Act further combine all of the vendor medical provisions for the aged, the blind, and the disabled. Federal matching share for cash payments for these of God's afflicted would also be increased; services for maternal, child health, crippled children, and the mentally retarded would be expanded; a 5-year program to provide comprehensive health care and services for needy children of school age or preschool age can now be authorized; and finally, these amendments wipe away restrictions on Federal participation in public assistance grants to aged individuals in TB or mental disease hospitals.

As Congressman at large for the State of Ohio, I believe that it is long overdue that the Congress increase benefits to the old-age, survivors, and disability insurance system by 7 percent. I am happy to note that this bill grants coverage to certain occupations, such as doctors and other employed persons. I applaud the amendment that provides for continuance of benefits to age 22 for certain dependent children in school.

Mr. Chairman, my constituency numbers 10½ million people in a growing industrial State, and daily that constituency makes requests upon my office that the Congress of the United States increase the amount an individual is permitted to earn without suffering full deductions from benefits of the present Social Security Act. The major amendments of the Social Security Act of 1965, as are before you for consideration, represent a program that is com-

prehensive in its tone and uniform in its application. It is a program which has avoided creating different classes of senior citizens. It is financially sound and does not depend upon the income test as provided in other proposals.

Mr. Chairman, the administration's medicare proposal is a compliment to the President and to the Congress and is a major step in effecting a sound health program for the Nation, based on the time-tested social security system. As the President said, health care for the elderly under social security is designed to lift a person's spirit, to remind him that he is a necessary part of the community deserving of the benefits he has worked to achieve; and since this plan will be purchased during the working years, the stigma of accepting charity will be completely removed. The hospital care and other benefits will have been earned.

Mr. Chairman, the passage by your committee and ultimately by the Senate of the United States, will supply the prudent, feasible, and dignified way to free the aged in this land from the fear of financial hardship in the event of illness. I am proud and delighted to recommend the passage of this legislation to your committee.

STATEMENT OF THE TEXAS MEDICAL ASSOCIATION ON TITLE III, H.R. 6675, COMPULSORY COVERAGE OF PHYSICIANS

The 9,300-member Texas Medical Association welcomes an opportunity to present a statement to the Senate Finance Committee on a provision in title III, H.R. 6675, which provides compulsory social security coverage for self-employed physicians and for interns and residents. Coverage and liability for taxes for physicians, interns, and residents would begin on January 1, 1966.

The Texas Medical Association wishes to express its opposition to that provision, and respectfully urges the Senate Finance Committee to delete it from H.R. 6675.

As members of the Senate Finance Committee are aware, social security is a tax program designed to require payment of specified percentages of earnings during the individual's working years in exchange for stipulated amounts paid for retirement, disability, and survivorship pensions.

Although there is no equity in the relationship between taxes to be paid and the amount of benefits which may be received, nevertheless, we do not believe that it is a purpose of the social security program to require individuals to pay these taxes and then to receive little or nothing in return. Yet, this is precisely what will happen to many physicians if they are forced to contribute to social security. In support of this statement, permit us to cite three points for your consideration.

1. Most physicians would have little prospect of receiving social security retirement benefits until reaching age 72. Social security retirement benefits are limited essentially to those who retire at age 65, and who have earnings of not more than $1,200 each year.

Most self-employed physicians rarely can count on retiring upon reaching age 65. Most physicians who are able to work are needed and prefer to keep right on practicing medicine. They do so because they still can utilize their knowledge and skill to minister to the sick, and because their patients still want them to continue to serve them. The physician does not suddenly lose his ability when he reaches age 65. Nor does the intimate physician-patient relationship suddenly come to a halt. The physician's concern for his patients continues beyond his birthday. Similarly, the patient's needs for his care bear no relationship to a retirement age written into a Federal law. In essence, any program which is built around a 65-year-old retirement age simply does not fit into the life and work pattern of most physicians.

A survey of physician retirement has shown that over 85 percent of the doctors between the ages of 65 and 72 are in active practice. More than 50 percent of the physicians who retire do so after age 74. Most of them are well able to care for themselves during their remaining years and to provide for their widows.

2. If compelled to participate in this program, the typical physician would be required to pay social security taxes until age 72 before he would actually start to receive benefits. Compulsory participation would represent an unfair tax to them. As embraced in H.R. 6675, self-employed individuals earning $5,600 or more would be required to pay $355.60 in social security taxes starting in 1966. In 1987, when the maximum hospital insurance tax would be effective

the self-employed individual earning $6,600 or more will be required to pay $514.80 annually.

3. Physicians prefer the privilege of establishing retirement benefits for themselves on a voluntary basis. We recognize that the program embraces survivorship benefits for a physician's widow and minor children, in addition to its retirement features. Nevertheless, most physicians in Texas prefer to continue to protect their families through existing private insurance mechanisms. They do not desire to participate in a compulsory program financed by taxes, and particularly to receive benefits for which their children must pay.

Members of the Texas Medical Association overwhelmingly indicated their position on participating in the social security program in 1956 when they expressed opposition to inclusion by more than 10 to 1 in a statewide poll. Since that time, samplings of opinion in various county medical societies indicate sentiment has not changed appreciably. This position has been reiterated almost annually by the association's 226-member house of delegates, which is comprised of the elected representatives of all county medical societies in our State.

Our purpose is not to evade paying our fair share of a tax program from which we shall derive ultimately some return. Rather, we prefer to continue to be excused from underwriting a program in which the benefits theoretically might be available to us, but which practically and in fact the needs of society will not permit us to use.

It hardly seems equitable to require inclusion of everyone in a program when some have little likelihood of ever being able to share in its benefits. When a profession, group, or individual is able, willing, and desires to take the responsibility for his or its own security without relying upon the Federal Government, we believe that they should be permitted to do so. In the past, the Senate has expressed respect for the rights of such groups to make provisions for their own security and has exempted them.

The Texas Medical Association is grateful for this opportunity to express its opposition to that provision in title III, H.R. 6675, which provides compulsory social security coverage for self-employed physicians and for interns and residents. Our association respectfully urges the Senate Finance Committee to delete that provision from H.R. 6675.

STATEMENT OF THE TEXAS MEDICAL ASSOCIATION ON HOSPITAL AND MEDICAL CARE PROVISIONS OF H.R. 6675

Texans sometimes are accused of telling tales about programs which are the biggest, the best, and the most outstanding of all. Nevertheless, we are extremely proud of many positive measures which have been initiated in our State to provide an effective program of medical care for the needy aged, and to assist in financing medical services for its 745,000 residents who are 65 years of age and older. These accomplishments have been made possible by joint cooperative efforts by the State of Texas, by physicians, hospitals, Blue Cross-Blue Shield of Texas, commercial insurance companies, nursing homes, and by those in allied health fields who devote their energies to the care of patients.

Texas has been the first State to use the mechanism of voluntary health insurance to implement the Kerr-Mills Act. This unique program is providing extensive benefits to 220,000 needy aged, representing more than 30 percent of the entire 65-and-over population of our State.

On the basis of our experience since January 1962 we can highly recommend the principle of voluntary health insurance in implementing the Kerr-Mills Act. It has provided old-age-assistance recipients with a program of high-quality medical care. These patients enter our hospitals with dignity. They merely present their Blue Cross insurance cards at any hour, day or night, like thousands of others who have purchased coverage for themselves. The use of the principle of health insurance has provided the maximum of professional and scientific freedom. It has permitted the administration of the program by a carrier which has longstanding experience in dealing with physicians and hospitals. Very importantly, it has resulted in more enthusiastic participation by Texas physicians and hospitals. The importance of this latter point cannot be emphasized too strongly. Obviously, it is difficult for any medical program to achieve success without the willing cooperation of physicians and hospitals.

It is noteworthy, too, that Blue Cross-Blue Shield and commercial companies are offering special health insurance policies for the aged. These include both

basic and major medical policies, such as the Texas 65 plan and the Senior Texan Service. These programs add up to a significant record of leadership. Texas ranks first among the States in the percentage of the aged who have one or more health insurance policies. An estimated 72 percent of the elderly in Texas are covered by health insurance as compared to the national level of 60 percent.

The Kerr-Mills Act created an entirely new program, medical assistance to the aged, for those 65 and older who are not on a State's old-age assistance rolls but who do need help in meeting medical care costs. The Kerr-Mills Act also substantially increased the amount of Federal funds available to the States for initiating new medical care programs for recipients of old-age assistance, or for improving those already in existence. The State of Texas has used this provision to good advantage. Following enactment of the Kerr-Mills Act by Congress in 1960, the Texas Legislature voted the following year to implement the first portion of that law. It established vendor payments of inpatient hospital care, professional services in the hospital, and nursing home care for recipients of old-age assistance. The Texas Department of Public Welfare was designated as the State agency to carry out the program. That agency was authorized to pursue one of three approaches:

First, to administer the program itself in its entirety.

Second, to contract with a fiscal agency which would make direct payments for services rendered, or

Third, to employ the principle of health insurance.

It should be noted that the Kerr-Mills Act specifically allows the use of Federal and State funds for payment of insurance premiums for medical and other types of remedial care.

State officials and leaders of the State medical and hospital associations agreed to use private health insurance as the instrument to implement the program. After evaluating competitive bids, the State department of public welfare awarded the contract to Blue Cross for a premium of $8.68 per month for each OAA recipient. Blue Cross guaranteed that it would not expend more than 3 percent of the total premiums for operational and administrative costs, and that it would make available the remaining 97 percent of each premium dollar for actual hospital, surgical, medical, and radiation benefits. The program was placed into operation on January 1, 1962. Coverage presently is provided for 229,000 recipients of old-age assistance.

The first 3 years of operation has been a real success story. The program is operating efficiently and effectively, and it has been extremely well received by the aged, by their families, by State officials, by physicians, and by hospitals. More than 7,500 patients are being admitted to hospitals monthly under the provisions of the program. Forty-one percent of the entire OAA caseload has been hospitalized during the past year. The average hospital stay of patients has been 9½ days. This is 3 days longer than the average stay for patients in general hospitals in the State, but it is 2 days less than had been anticipated in the OAA program. Experience has shown that 87 percent of those hospitalized are confined for 15 days or less. For these patients, the Blue Cross insurance policy is paying 88 percent of the total hospital bill. The remaining hospital charges have not placed a burden or a hardship upon the patient. In some cases, OAA recipients have additional health insurance policies of their own. Some children and relatives of the aged are willing to pay the remainder, or a part of it. Several local municipalities and counties provide some funds for health services for their needy. In other instances, the hospital itself has been "charging off" the difference between customary charges and benefits provided by Blue Cross.

Texas physicians have contributed substantially to the success of this most worthy program. It is significant that almost all of our association members are accepting Blue Shield benefits as payment in full. These insurance payments have represented about 55 to 60 percent of the usual and customary fees charged by physicians.

The total cost of hospital and professional services is running about $23 million a year. Even though more than 40 percent of the OAA caseload is being hospitalized each year, it is highly comforting that this insurance approach is financially sound. As a result of the favorable experience during the first year, it was possible to increase benefit schedules paid on behalf of patients, effective January 1, 1963.

A major factor in the success of the Texas program has been its very efficient administration by Blue Cross-Blue Shield.

Blue Cross has guaranteed to the State of Texas that it would administer the program for not more than 3 percent of the total premium. That pledge has been fulfilled. It is doubtful if any medical program financed by tax moneys can be administered more economically or more effectively.

Texas' comprehensive program also includes nursing home benefits. This phase of the Kerr-Mills program is being administered directly by the State department of public welfare. Payments in the amount of $20 million a. being made for nursing home care each year. Thus, the total annual cost to taxpayers is about $43 million.

Complementing the Kerr-Mills program are two fine voluntary health insurance plans which have been especially tailored for the aged. Those plans are underwritten by Blue Cross-Blue Shield of Texas and by the Texas 65 Health Insurance Association. They reflect the great progress which has been made in the past few years in offering good coverage to the elderly at reasonable premiums. In October 1959, Blue Cross conducted a special 1-month promotional campaign to enroll the aged. That campaign was most successful. Since that time, Blue Cross-Blue Shield has intensified its efforts, and it now offers a comprehensive plan of health care benefits prepared exclusively for the aged. This plan, called Senior Texan Service, offers medical and surgical benefits for a premium of $3.20 a month, and hospital and nursing home services for a monthly premium of $8.75. This plan supplements other policies which are made available to the aged by Blue Cross-Blue Shield. It is noteworthy that more than 100,000 persons over age 65 now are covered by policies written by Blue Cross-Blue Shield. This is in addition to the 229,000 on old-age assistance who hold policies which have been purchased for them by the State of Texas.

In October 1963 a special program of low-cost health insurance was introduced to the Texas aged by a group of leading insurance companies. The Texas 65 plan was made possible by the State legislature which authorized companies to pool their resources, and to form a health insurance association. As a public service, 64 companies are underwriting the benefits on a nonprofit basis. Texas 65 offers two basic policies—a basic plan of hospital and medical care with a premium of $9 per month and a program of major medical or catastrophic coverage for a monthly premium of $10.

These plans are made available to all residents of Texas 65 years of age and over without physical examination and with no health questions asked. Even those with preexisting illnesses were invited to enroll. After a reasonable waiting period, they can qualify for coverage for a recurrence of those illnesses.

More than 50,000 elderly Texans have purchased health insurance policies during the initial and two subsequent enrollment periods. The average age of the Texas 65 policyholder is 73 years. The average enrollee is a previously uninsurable female.

Through April 30, 1965, Texas 65 has paid $4,645,917 claims to 24,486 senior citizens. It is evident that Texas 65 is accomplishing the objective it set out to do; that is, to provide the peace of mind that only health insurance can do for the State's elderly residents and their sons and daughters who otherwise would have to pay these expenses out of their own pockets.

Thus on the basis of our experience in Texas, voluntary prepayment health insurance is proving to be an effective mechanism for financing health care costs for the aged.

It is possible to present documentation that nearly all of the elderly in the State who want and need help in financing health care costs now are receiving it. Shortly after the Kerr-Mills Act was implemented in 1962, Belden Associates of Dallas conducted an extensive study of the Texas aged and their attitudes on health care. Belden's survey was concentrated on the aged who are not recipients of the old-age assistance as well as the younger adults who are associated with them. The study by this independent research firm was particularly significant, inasmuch as it focused attention on the 524,000 remaining aged and their possible needs and desires for medical care.

According to Belden, 23 percent of these aged said that they did without necessities during the previous year because of lack of money. Three percent stated that they did without medicine; 4 percent, without medical care; and 1 percent, without surgery.

With regard to the attitude of older persons on providing health care needs, 61 percent expressed the view that it was a responsibility which should be borne

by the aged person or by the family. Eighteen percent were inclined to lean on the local and State governments for help, while 19 percent indicated that it was the responsibility of the Federal Government.

Younger adults associated with these older people expressed themselves even more forcefully in favor of the principle of individual responsibility. Seventy-two percent felt that the responsibility should be that of the aged person or the family. Only 12 percent expressed the view that it was a local or State responsibility, and 14 percent, a Federal obligation. These views were voiced before the OAA program was well established and prior to the introduction of the Texas 65 insurance plan. It is reasonable to assume that there is even less support today for Federal medical programs.

Belden also uncovered factual data on the extremely high percentage of the Texas aged who presently have one or more health insurance policies. Based upon the study findings and a conservative estimate of changes since that time, an estimated 537,000, representing 72 percent of the entire aged population, now have health insurance coverage. In view of others with sufficient incomes and savings, those who are helped financially by their families and by their children, and those who have expressed the belief that they should take care of themselves, Belden has concluded that there remains approximately 3 percent of all aged Texans who still need and want outside help.

Plans have been developed to assist this small remaining group. In 1963, the Texas Legislature authorized the submission of a constitutional amendment to the voters of the State which would permit the extension of the present Kerr-Mills program by providing health care benefits for those who need and want help, but who do not qualify for old-age assistance. This is the second phase, or medical assistance to the aged program, of the Kerr-Mills Act. This past November, the voters of Texas overwhelmingly by 71 percent approved constitutional amendment 3. This constitutional amendment will permit the State legislature, now in session in Austin, to complete the Texas program for the aged which, we believe, already ranks as one of the finest in the Nation.

In summary, significant progress has been made in just a few short years. The State of Texas has an effective, economical program for 229,000 needy aged. Texas leads the Nation in the percentage of the aged who have one or more health insurance policies. The Belden study has shown that almost all aged who need and want help are receiving it, and legislative machinery is operating to help those few who still need help.

In supporting these highly effective programs, the Texas Medical Association obviously stands in favor of a positive program. Our physicians believe that medical care should be made available to those who are not able to pay for it themselves. We support the Kerr-Mills law which is designed to assist those who need help. We favor the continued expansion of voluntary health insurance to enable those who are solvent and self-supporting to protect themselves against the cost of illness. We are for flexible, voluntary retirement programs in business and industry so that the productive capacity of older employees will continue to serve society, with assurance of security when they reach retirement. Most importantly, we are for the preservation of the freedom of the individual to spend his own dollars in his own way, and not for those in Government to spend his money for him.

The Texas Medical Association is firmly opposed to H.R. 6675 because a compulsory system is neither needed nor wanted in Texas. As outlined in the statement, Texas has formulated an outstanding program of medical care for the aged, and there is no need for a new Federal program.

Nor is such a program wanted by the people of our State. Six Texas Congressmen have conducted public opinion polls among their constituents, and they have reported opposition to social security financed medical care.

The public has been asked to believe that this program of Government-financed and Government-managed health care would yield more and better treatment at less cost. We believe that it would give less and poorer care at greater cost. We are most concerned about Federal regulations and controls, and their adverse effect on the quality of medical care. We are concerned about those who would take advantage of this Government program because they believe that they will be entitled to its benefits, and thus would overload our hospitals and nursing homes, just as has been done in those countries with compulsory systems. We are concerned because the Government would undercut and disrupt continuing progress in health insurance by the commercial companies and by Blue Cross-Blue Shield.

Most importantly, we are concerned about the exploitation of the younger working people of our country and their employers. Medicare would use their tax dollars to provide benefits to all older citizens, including thousands who are not needy and who are fully able to take care of themselves.

We fear that the provisions for health care contained in H.R. 6675 represent only a beginning. Medical care and hospital benefits undoubtedly will be expanded in the years ahead. The cost will be further increased as America's aged population goes up from 18½ million at present to a predicted 27 million by 1975. Sooner or later, there will be a demand from those who are paying the taxes to obtain coverage in this Government program. This legislation could very well lead to a complete program of Federal medical and hospital care.

After considering specific provisions of H.R. 6675, the Texas Medical Association wishes to comment particularly on three of them. We wish to recommend the use of carriers for the administration of benefits in order to insure maximum freedom of the physician in his relationships to private carriers and to the Department of Health, Education, and Welfare.

The Texas Medical Association also wishes to express its opposition to the Douglas amendment which would place the services of pathologists, anesthesiologists, radiologists, and physiatrists under hospital services in section 1 of H.R. 6675. The practice of pathology, radiology, anesthesiology, and physical medicine are branches of the practice of medicine just as are surgery, general practice, and internal medicine. The services of these physicians are not hospital services and they do not belong in that portion of the bill solely designed to offer hospital benefits.

The Texas Medical Association also wishes to express its opposition to section 303 of H.R. 6675. We are particularly concerned about the proposed deletion of the "permanent and total disability" concept for it would result in transforming the cash disability provisions into a cash sickness benefits program with a 6-month waiting period at first. Section 303 would make it possible for an individual who is out of work for 6 months by reason of any medically determinable mental or physical impairment to draw double benefits. Many disabled individuals could draw more in combined tax-free social security disability benefits and workmen's compensation than they could hope to earn in wages. These individuals obviously would have little or no financial incentive to seek rehabilitation.

The Texas Medical Association will be most grateful for any consideration which the Senate Finance Committee may give to these views.

STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION, SUBMITTED BY CARL E. MORRISON, D.O., OF TUCSON, ARIZ., CHAIRMAN, COUNCIL ON FEDERAL HEALTH PROGRAMS

The American Osteopathic Association appreciates this opportunity for comment on the House-passed social security medicare bill, H.R. 6675, 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 OASDI system, and to improve the Federal-State public assistance programs.

The association is a nonprofit, tax-exempt federation of divisional societies of osteopathic physicians and surgeons. It promotes the public health, encourages scientific research, maintains and improves high standards of medical education in osteopathic colleges, establishes standards of accreditation of osteopathic hospitals, and standards for accreditation of skilled nursing homes.

The practice of osteopathic medicine is legalized in all the States. Thirty-nine States and the District of Columbia license osteopathic graduates to perform major operative surgery and to administer all drugs.

More than 300 hospitals, most of which are general hospitals serving patients of all ages and all types of illness are staffed by osteopathic physicians and surgeons. According to statistics compiled by the American Osteopathic Hospital Association, during 1963 more than 310,000 operations ranging from tonsillectomies to gastric resections were performed in these hospitals. Some 362,000 patients were admitted and received more than 4,534,000 patient-days of care in 1964.

Under the Hill-Burton program 70 osteopathic projects (general hospitals, chronic disease facilities, rehabilitation facilities, nursing homes, and diagnostic and treatment centers) costing more than $57 million have received Federal support of more than $19 million for construction.

Manifestly, the health resources of the osteopathic profession and institutions must be a significant factor in the successful operation of the programs proposed in H.R. 6675, and as pointed out by Government and public witnesses, page 250 of the published Executive Hearings before the House Ways and Means Committee on Medicare for the Aged, January–February, 1965, it is clear that as used in the proposed legislation the terms physician and physicians' services include osteopathic physicians and the services of osteopathic physicians and the term hospital includes hospitals staffed by osteopathic physicians and surgeons.

Title I is concerned with health insurance for the aged and has two parts. Part I has three subparts: Part A would establish a hospital insurance program patterned after the King-Anderson bill; part B would establish a voluntary, federally administered health insurance program to provide benefits which supplement the benefits under the King-Anderson program; and part C contains definitions and provisions relating to the administration of parts A and B. Part 2 of title I would establish a new program which would replace the existing programs for medical assistance under the public assistance programs.

Title I amends the OASI provisions of the Social Securiyt Act to add a new title XVIII, the first two sections under which (secs. 1801 and 1802) provide against Federal interference, with the practice of medicine and provide that 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 the institution, agency, or person undertakes to provide him such services.

TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

Part 1–A—Health insurance benefits for the aged

This part provides basic protection against the costs of hospital and related posthospital services to any individual 65 years of age or over who is entitled to monthly insurance benefits under title II of the Social Security Act or under the Railroad Retirement Act, whether or not he is receiving them and to any individual 65 years of age who is not entitled to benefits under the social security or railroad retirement laws, who becomes that age before 1968.

Payment for services would be provided only if: (1) a written request is filed by the entitled individual and (2) a physician certifies and recertifies (accompanied by supporting material) that the type of service is medically necessary.

Payment for services would be made to providers of services at least on a monthly basis, provided they have entered into agreements with the Secretary. Payment would be based on "reasonable costs" of services as prescribed in regulations for determining costs.

If a group or association of providers wishes to have payments made through a National, State, or other public or private agency, the Secretary would be authorized to enter into an agreement with the agency.

Part 1–B—Supplementary health insurance benefits for the aged

This part of the bill would establish a voluntary insurance program to provide health insurance benefits for individuals 65 or over who elect to enroll under it. It would be financed from premium payments by the enrollees and by funds appropriated by the Federal Government.

Benefits would include payments to the individual or to the provider of services for: (*a*) physicians' services and (*b*) medical and other health services with exceptions. Payments would be made to providers of services for: (*a*) inpatient psychiatric hospital services; (*b*) home health services; (*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.

No payment could be made under part I–B for any services for which the individual is entitled to have payment made under part I–A.

The provisions requiring a written request by the eligible individual, certification and recertifications of the need for services by a physician are essentially the same under this part as under part 1–A.

To administer the program, the Secretary would have to enter into contract with carriers. A "carrier" would mean 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 policies 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. The term would include a health benefits plan sponsored or underwritten by an employee organization. It would also include any organization nominated by providers of services with which the Secretary has entered into an agreement under part 1-A. It could include the State agency with which the Secretary enters into an agreement described below.

At the request of a State made prior to July 1, 1967, the Secretary would have to enter into an agreement to provide coverage under this part for either: (a) persons receiving money payments under OAA or the combined program of aid to the aged, blind, or disabled, or (b) persons receiving money payments under all the public assistance programs. However, individuals in the above categories who are receiving benefits under the social security or railroad retirement program would have to be excluded.

Part 1-C—Definitions and administration

"Inpatient hospital services" would consist of bed and board, nursing and related services, use of hospital facilities, medical social services ordinarily furnished by the hospital, and such drugs, biologicals, supplies, appliances, and equipment for use in the hospital furnished by the hospital for in-patients, diagnostic and therapeutic items or services furnished by the hospital or by others under arrangements with the hospital for its patients. It would not include medical or surgical services provided by a physician, resident, or intern, or the services of a private-duty nurse or other private-duty attendant. It would include all types of services rendered in a hospital by an "intern or 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)" (sec. 1861 (b)).

Eighty-nine osteopathic hospitals are currently approved by the American Osteopathic Association for intern training, 65 of which are also approved for resident training. Before being considered eligible for admittance to an osteopathic college, students must spend at least 3 years in an approved college or university. Most matriculants have baccalaureate degrees. The professional curriculum of an osteopathic college requires at least 5,000 hours of instruction over 4 college years. After receiving the D.O. degree, 90 percent of graduates serve a 12-month intership in an osteopathic hospital approved for such training. Certification in a specialty field requires about 5 additional years of training, including residency and supervised study. Osteopathic specialties include surgery, radiology, anesthesiology, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, psychiatry, internal medicine, dermatology, proctology ophthalmology and otorhinolaryngology, and pathology.

State and Federal agencies concerned with osteopathic internships and residencies rely on accreditation by the American Osteopathic Association. For example, the U.S. Civil Service Commission qualification standards for medical officers, medical officer series GS-602, page 8, published March 1963, provide:

"A. Use of terms.

"1. Approved internship: This is training in a hospital or other institution approved by the Council on Medical Education and Hospitals of the American Medical Association or by the Bureau of Professional Education, Committee on Hospitals of the American Osteopathic Association for internship training.

"2. Approved residency: This is training in a hospital or other institution approved by the Council on Medical Education and Hospitals of the American Medical Association or by the Bureau of Professional Education, Committee on Hospitals of the American Osteopathic Association for training in the specialty.

"3. Internships and residencies. The 0-month wartime approved internships and residencies during the period from December 31, 1942, to July 1, 1947, will be accepted as the equivalent of 1 year.

"4. Accredited preceptorship training. Preceptorship training is training under the direction of an individual physician who is recognized in the specialty concerned. Such training is not necessarily obtained in the hospital setting. In order to be accredited, applicants must furnish a certificate of acceptance by any approved American specialty board in the specialty concerned.

"5. An approved American specialty board is one which has been approved for the particular specialty by the Council on Medical Education and Hospitals of the American Medical Association or by the Bureau of Professional Education, Advisory Board for Osteopathic Specialists of the American Osteopathic Association."

A "hospital" is defined under this part as an institution, which: (1) is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of such persons; (2) maintains clinical records on all patients; (3) has bylaws 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 services rendered or supervised by a registered professional nurse, and has a licensed practical nurse or a registered professional nurse on duty at all times; (6) has a "hospital utilization review plan"; (7) is licensed pursuant to State or local law or is approved by the State or local agency which licenses hospitals as meeting the standards established for licensing; and (8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals furnished services in the institution, except that such other requirements could not be higher than the comparable requirements prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals.

No accreditation is necessary in order to establish eligibility, but accreditation as provided in section 1865 of the bill can establish eligibility.

A "psychiatric hospital" is defined as an institution primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, which meets the requirements (3) through (8) for a hospital as defined above, and which meets requirements equivalent to the accreditation requirements of the Joint Commission on Accreditation of Hospitals (sec. 1861(f)).

An "extended care facility" would mean an institution, or a distinct part thereof, which has in effect a transfer agreement with a hospital which has entered into an agreement to provide services under the bill and which: (1) is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services; (2) has policies which are developed with the advice of a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the services the facility provides; (3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies; (4) has a requirement that every patient be under the care of a physician, and provides for having a physician available to furnish medical care in case of emergencies; (5) maintains clinical records on all patients; (6) provides 24-hour nursing service in accordance with the policies developed with the advice of a group of professional personnel and has at least one registered professional nurse employed full time; (7) provides appropriate methods and procedures for dispensing and administering drugs and biologicals; (8) has in effect a utilization review plan which meets the requirements of the bill; (9) is licensed under State or local law or is approved by the State or local agency responsible for licensing such facilities as meeting the standards established for licensing; and (10) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of the individuals furnished services by or in the facility. The term would not include any institution which is primarily for the care and treatment of tuberculosis or mental diseases (sec. 1861(j)).

In defining a "utilization review plan" the bill requires a review, on a sample or other basis, of admissions to the hospital or extended care facility, duration of stays, and professional services (including drugs and biologicals) furnished with respect to the medical necessity for the services and to promote the most efficient use of facilities and services, the review to be made either by a staff committee of the institution composed of two or more physicians with or without professional personnel or by a similarly composed group outside the institution established by the local medical society or a group established in a manner approved by the Secretary. It is understood that the term "local medical society" is applicable to local societies of either doctors of medicine or doctors of osteopathy (sec. 1861(k)).

A "home health agency" would be an agency which: (1) is a public or private nonprofit organization or a subdivision thereof and which is primarily engaged in providing skilled nursing and other therapeutic services; (2) has policies established by a group of professional personnel associated with the agency, including one or more physicians, and one or more registered professional nurses, to govern the services it provides, and provides for supervision of the services by a physician or a registered professional nurse; (3) maintains clinical records on all patients; (4) is licensed under State or local law or is approved by the State or local licensing agency as meeting standards established for licensing such agencies; and (5) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of the patients (sec. 1861(o)).

Extended care services (1861(h)(6)), and home health services (1861(m)(6)), include medical services by interns and residents in training under teaching programs of affiliated hospitals approved by the AOA.

"Outpatient hospital diagnostic services" would be services which are furnished to an individual as an outpatient by a hospital, or by others under arrangements with them made by the hospital, which are customarily furnished by the hospital to outpatients for the purpose of diagnostic study, excluding any service furnished under an agreement, unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff (sec. 1861(p)).

"Physicians' services" would mean professional services performed by physicians, including surgery, consultation, and home, office, and institution calls, but not inpatient hospital services (sec. 1861(q)).

"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))" (sec. 1861(r)).

The above definition of "physician" incorporates by reference section 1101(a)(7) of the Social Security Act, adopted in 1950, which expressly includes doctors of osteopathy in the definition of "physician" under the general provisions of the Social Security Act (64 Stat. 559).

It was through application of the criterion that in order to qualify for inclusion under the term "physician" as used in the Social Security Act generally, one must be trained in the practice of the healing art in all its branches, that this committee in 1950, based upon the evidence submitted, found that graduates of the osteopathic schools of medicine so qualified and included them under section 1101(a)(7).

The Congress similarly defined the terms "physician" and "medical care" and "hospitalization" as inclusive of osteopathic physicians and hospitals under the provision of the U.S. Employees Compensation Act in 1938 (52 Stat. 586).

Previous to that, in 1929, the Congress, in regulating the practice of the healing art in the District of Columbia, provided: "the degrees of doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations" (45 Stat. 1329).

Osteopathic physicians and hospitals are used in the Medicare program for dependents of members of the uniformed services, by the Veterans' Administration, by the Bureau of Employees' Compensation, and in the Federal employees health benefits program, Government-wide service benefit plan administered by Blue Cross and Blue Shield, and Government-wide indemnity benefit plan administered by AETNA Life Insurance Co.

"Consultation with State agencies and other organizations": In carrying out his functions relating to determination of conditions of participation by providers of services in the case of hospitals under subsections (e)(8), extended care facilities under (j)(10), and home health agencies under (o)(5), of section 1861, the Secretary is required to 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 (sec. 1863).

"Use of State agencies": The Secretary would have to make an agreement with any State able and willing to do so, to utilize the services of State health agencies or other appropriate agencies (including local agencies) to determine whether an institution is a hospital, extended care facility, or home health agency. To the extent that the Secretary finds it appropriate, an institution or agency which a State (or local) agency certifies is a hospital, extended care

facility, or home health agency (as defined in sec. 1861) may be treated as such by the Secretary. The Secretary may also, pursuant to agreement, utilize the services of State health agencies to provide consultative service to institutions or agencies to assist them to qualify as providers of services (sec. 1864).

"Effect of accreditation": The Secretary is required to accept accreditation of a hospital by the Joint Commission on the Accreditation of Hospitals as meeting all the requirements of a hospital as defined in section 1861(e), excepting the requirement of a utilization review plan which is not now a condition for accreditation by the joint commission. In addition, if the Secretary finds that accreditation of a hospital, nursing home, or home health 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 findings" (sec. 1865).

Inasmuch as requirements for hospital accreditation and nursing home accreditation by the American Osteopathic Association equal or exceed the requirements specified in sections 1861(e) and 1861(j), including AOA requirement of a utilization review plan effective July 1, 1965, the express recognition of the American Osteopathic Association in the above provision as the accrediting agency for these institutions justifies the assumption that such accreditation will be found to confer acceptability, and stability of assurance.

Two hundred of the more than 300 osteopathic hospitals are accredited by the American Osteopathic Association. The accredited hospitals include 98 teaching hospitals and 111 registered (as distinguished from listed) hospitals.

Minimum standards of organization and practice for hospitals staffed by osteopathic physicians and surgeons were first established, and inspection and approval procedures adopted, by the American College of Osteopathic Surgeons about 1928. In 1935, the Bureau of Hospitals of the American Osteopathic Association assumed joint responsibility with the American College of Osteopathic Surgeons. Since 1949, the American Osteopathic Association has had full responsibility, which it now exercises through a committee on hospitals.

The committee on hospitals of the American Osteopathic Association is composed of four representatives of the osteopathic profession at large and a representative from each of the specialty colleges of surgery, radiology, internal medicine, and obstetrics and gynecology. They are thoroughly familiar with all phases of hospital administration and are charged with the formulation of hospital standards which are formally approved by the board of trustees of the American Osteopathic Association.

Any hospital desiring accreditation must submit to a rigid annual examination by the committee. If the hospital passes this examination it can be officially listed as registered. Hospitals which are approved for internship or residency training must pass an annual inspection even more comprehensive than that for registered hospitals. State and Federal agencies have recognized AOA accreditations.

"Health Insurance Benefits Advisory Council": To advise the Secretary on matters of general policy in the administration of the program and in formulation of regulations, there would be created a 16-man Health Insurance Benefits Advisory Council appointed by the Secretary, members of which would have to include persons outstanding in the fields pertaining to hospitals and medical and other health activities. We hope the Secretary will give favorable consideration to appointment of at least one member with an osteopathic background (sec. 1867).

"National Medical Review Committee": The bill establishes a nine-man National Medical Review Committee, a majority of whom must be physicians. The Secretary would be required to select individuals "who are representative of organizations and associations of professional personnel in the field of medicine." The committee would study the utilization of hospital and other medical care and services paid for under the program and recommend changes considered desirable. A representative of the American Osteopathic Association should be a member of the committee (sec. 1868).

Part 2—Grants to States for medical assistance programs

This part improves and extends the Kerr-Mills program by establishing a new title (XIX) in the Social Security Act to furnish medical assistance on behalf of families with dependent children and on behalf of aged, blind, or permanently

and totally disabled individuals whose income and resources are insufficient to meet the costs of necessary medical care. To be eligible for a grant, a State would have to submit a plan for medical assistance which has been approved by the secretary.

An approvable State plan must provide for inclusion, effective July 1, 1967, of at least the following care and services: "(1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; and (5) physicians' services, whether furnished in the office, the patients' home, a hospital, or a skilled nursing home or elsewhere." Inclusion of other care and services would be optional (secs. 1902 and 1905).

The above five categories of services which the States would be required to include in their plans, if they elect to implement title XIX, would include the services of osteopathic hospitals and osteopathic physicians, notwithstanding their listing in House Report No. 213 as optional. In clear and unambiguous language, the definition of physician and hospitalization in section 1101(a)(7) of the Social Security Act expressly includes the legalized services of osteopathic physicians and hospitals, applicable throughout the titles of the act.

TITLE II—OTHER AMENDMENTS RELATING TO HEALTH CARE

Part 1—Maternal and child health and crippled children's services

"Special project grants for health of school and preschool children": The Secretary would be authorized to make grants "to any school of medicine" and "to any teaching hospital affiliated with such a school" to pay the costs of projects of a comprehensive nature for health care and services for children and youth of school age or preschool children (to help them prepare to start school). A project would be considered "comprehensive" if it includes at least screening, diagnosis, preventive services, treatment, correction of defects, and aftercare as may be provided in the Secretary's regulations. The grant could be up to 75 percent of the cost of the project.

No project would be eligible unless it provides for the coordination of the health care and services with, and the utilization of, other State or local health, welfare, and education programs, for payment of inpatient hospital services under the project in accordance with standards approved by the Secretary, and unless any treatment, correction of defects, or aftercare provided 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.

It is understood that the terms "school of medicine" and "teaching hospital affiliated with such a school" include colleges training osteopathic physicians and hospital affiliated therewith and services of hospitals staffed by osteopathic physicians and surgeons.

In conclusion, the osteopathic profession and its institutions can be relied upon to employ their best efforts to provide and safeguard quality care and to pursue their traditional role of cooperation in the public interest.

We will be pleased to aid the committee in any way we can.

COMMONWEALTH OF VIRGINIA,
DEPARTMENT OF VOCATIONAL REHABILITATION,
Richmond, May 12, 1965.

Re proposed amendment to S. 6675.

Hon. HARRY F. BYRD, Sr.,
U.S. Senator,
Washington, D.C.

MY DEAR SENATOR BYRD: I am sending you a copy of a proposed amendment to S. 6675 now under consideration by your Senate Finance Committee. I am sorry that I will not be able to contact you personally in regard to this but I am returning to Little Rock, Ark., tomorrow and for the next few days thereafter will be involved in moving my household furniture to Richmond, Va.

The proposal is to amend section 222 of the Social Security Act to permit payment of the cost of vocational rehabilitation services for disabled beneficiaries of social security from the OASDI trust fund. Demonstration programs over the past 3 years have shown that approximately 35 percent of the beneficiaries of this program have sufficient work potential to warrant referral to the State

vocational rehabilitation agencies. It is a reasonable estimate to expect that a minimum of the 20,000 of the disabled beneficiaries can be rehabilitated each year if adequate resources are made available to the State vocational rehabilitation agencies. If the temporarily totally disabled also become eligible for disability benefits this number could easily be doubled. It is particularly important that this "temporary" group receive rehabilitation services promptly, otherwise many will become long-term disability cases.

At the present time each State vocational rehabilitation agency has the responsibility for providing vocational rehabilitation services to all the disabled in the State including the disabled beneficiaries of social security. The Federal funds used by the State rehabilitation agency must be matched with State funds ranging from 50 percent in the higher income States to 70 percent in the lower income States. Virginia must provide 1 State dollar for each 2 Federal dollars. At the present time each State must use its State tax money in the rehabilitation of the disabled beneficiaries of social security. It is felt the social security trust fund should bear the responsibility of paying for the needed vocational rehabilitation services of their recipients and that State tax funds should not be required in providing rehabilitation services for this group.

In actuality expenditures from the trust fund for vocational rehabilitation services for recipients of disability benefits will result in a net saving to the trust fund. Experience has revealed that it costs approximately $1,200 to provide vocational rehabilitation to a disabled beneficiary. On the other hand, a disabled beneficiary may expect to receive about $9,000 in benefits if he has no dependents and about $17,000 if he has dependents. It is our belief that each disabled beneficiary that is rehabilitated will save the trust fund from 5 to 10 times the amount actually spent in his rehabilitation.

Safeguards are provided in the amendment and the regulations which would result therefrom to assure an orderly approach in the financing of rehabilitation services from the trust fund. We recognize that payment should start on a small scale and be expanded as experience is gained and the results documented. You will note that the amendment specifies in subsection (b)(1) that the total amount that can be transferred from the trust fund in any fiscal year may not exceed 2 percent of the benefit payment certified in the preceding year.

It is my understanding that this proposed amendment has been drafted by General Counsel and has the approval of the Social Security Administration and the Vocational Rehabilitation Administration although it is not an Administration sponsored amendment. It is something, however, that I have been working on for several years with Senator J. W. Fulbright of your committee and Representative Wilbur Mills, chairman of the House Ways and Means Committee. I commend this proposed amendment to you and sincerely hope that your study of it will result in your support. It will mean that in Virginia we will be able to use our State funds to earn Federal vocational rehabilitation funds for the provision of services to persons other than those who are covered by social security and use social security trust funds in the rehabilitation of those who are disabled beneficiaries of social security.

I will be more than pleased to provide you with any additional information you may desire. I am taking the liberty of sending a copy of this letter to Senator Robertson and Senator Fulbright with the request that they also study the proposed amendment and join you in support of it if they are in agreement with the principle involved.

Sincerely yours,

DON W. RUSSELL, *Director.*

PAYMENT OF COSTS OF REHABILITATION SERVICES FROM TRUST FUNDS (AN AMENDMENT TO S. 6675)

Section 222 of the Social Security Act is amended by redesignating subsections (b) and (c) as subsections (c) and (d), respectively, and by inserting after subsection (a) the following new subsection:

"Costs of rehabilitation services chargeable to trust funds

"(b)(1) For the purpose of making vocational rehabilitation services more readily available to disabled individuals who are (A) entitled to disability insurance benefits under section 223, or (B) in a period of disability under section 216(i) or (C) entitled to child's insurance benefits under section 202 (d) after having attained age 18, to the end that savings will result to the trust funds as a result of rehabilitating the maximum number of such individuals into productive

activity, there are authorized to be transferred from the trust funds such sums as may be necessary to enable the Secretary to pay the costs of vocational rehabilitation services for such individuals, including necessary costs of administration, except that the total amount transferred from the trust funds under this subsection in any fiscal year may not exceed 2 percent of the benefit payments certified in the preceding year pursuant to section 202(d) for children who have attained age 18 or pursuant to section 223.

"(2) In the case of each State which is willing to do so, such vocational rehabilitation services shall be furnished under a State plan for vocational rehabilitation services which—

"(A) has been approved under section 5 of the Vocational Rehabilitation Act,

"(B) provides that such services will be furnished with reasonable promptness to any such individual in the State to the extent funds provided under this subsection are adequate for the purpose and, in case such funds are not adequate to provide such services to all of them, shows the order to be followed in selecting those to whom such services will be provided, such order to be based on criteria formulated by the Secretary which take into account the relative effect upon the trust funds of providing such services to such individuals; and

"(C) provides that such services will be furnished to any such individual without regard to (i) his citizenship or place of residence, (ii) his need for financial assistance except as provided in regulations of the Secretary in the case of maintenance for an individual living at home while receiving rehabilitation services, or (iii) any order of selection followed under the State plan pursuant to section 5(a)(4) of the Vocational Rehabilitation Act.

"(3) To the extent that vocational rehabilitation services cannot be provided to any such individual in any State under a plan of such State which meets the requirements of paragraph (2), the Secretary may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals.

"(4) Payments under this subsection may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

"(5) Money paid from the trust funds under this subsection for purposes of providing services to individuals who are entitled to benefits under section 223 or who are within a period of disability under section 216(i) shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid out from the trust funds under this subsection shall be charged to the Federal Old Age and Survivors Insurance Trust Fund. The Secretary shall determine according to such methods and procedures as he may deem appropriate

"(A) the total cost of the services provided under this subsection; and

"(B) subject to the provisions of the preceding sentence, the amount of such cost which should be charged to each of such trust funds.

"(6) For the purposes of this subsection the term 'vocational rehabilitation services' shall have the meaning assigned to it in the Vocational Rehabilitation Act, except that such services may be limited in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purposes of this subsection."

BLOOMFIELD, CONN., *April 27, 1965.*

Hon. THOMAS J. DODD,
U.S. Senate, Washington, D.C.

DEAR SENATOR DODD: I am writing you to express my strong opposition to certain provisions of the omnibus social security bill and to urge you to work for the elimination or modification of these provisions.

As far as title XVIII, part A, is concerned, I fail to see the justification for providing through increased taxes compulsory hospital insurance for persons over 65 regardless of whether they want, need, or can afford to pay for this type of coverage. Surely there is no need to push already high taxes still higher by providing unneeded benefits.

Part B of title XVIII, providing coverage for physician's fees, does so in part through Government subsidy. In other words, the Government proposes to offer insurance covering certain medical expenses in direct competition with the very same private insurance firms which are being taxed to provide revenue from which subsidies may be paid. How indeed can this perversion of the free enterprise system be justified?

Finally, as I understand it, the bill will provide disability income benefits without the present limitation of a 6-month waiting period or of a requirement that disability be of the so-called permanent type. This would not only increase enormously the amount of benefits payable but would also increase the possibility of abuse. Furthermore, there appears to be nothing in the present bill to prevent its duplicating the benefits provided by workmen's compensation.

If these provisions are allowed to remain, the present bill would, in my opinion, contain very serious defets. I would appreciate your letting me have an expression of your opinion on these matters.

Very truly yours,

TIMOTHY W. GOODRICH II.

THE NEW YORK ACADEMY OF MEDICINE,
New York, N.Y., May 11, 1965.

Re H.R. 6675.

Hon. HARRY F. BYRD,
Senate Office Building, Washington, D.C.

MY DEAR SENATOR BYRD: The New York Academy of Medicine desires that the elderly shall have adequate, high-quality medical care. For some time there have been provisions for the indigent elderly; more recently, through MAA, medical assistance was extended to the medically indigent. For 4 years the academy's committee on public health has deliberated upon the ways and means of providing medical care for the medically indigent among the elderly.

With the introduction and passage in the House of H.R. 6675 the academy has carefully studied its contents:

First, the academy notes that coverage of the services of medical specialists in the fields of pathology, radiology, physiatry, and anesthesiology is conspicuously excluded under the hospitalization porgram. This exclusion would have a number of adverse effects. The most serious are (1) substantial reduction in the benefits that aged beneficiaries will receive; and (2) profound disturbance of the existing relationships between hospitals and physicians with ultimate repercussions on the public.

The academy therefore strongly supports amendment 70 introduced by Senator Douglas which would make the costs of these services reimbursable under the hospitalization plan.

The remainder of the academy's comments pertain to those parts of the bill entitled "Medical Assistance Programs and Health Care."

The academy would emphasize its conviction that MAA will have continued importance as a backup after the benefits under the hospitalization and health insurance plans have expired.

From the inception of MAA, the academy expressed the desire that this program become effective. It published two reports on MAA, one shortly after it was enacted and the other in 1964, following a review of 3 years' experienec with it. In both reports the academy recommended steps for its improvement.

From the record of MAA, the academy was concerned over the reported misuse of its benefits for those for whom they were not intended, particularly OAA; and underuse by those for whom they were intended.

To remedy the former defect, the academy recommends that the language of the bill clearly specify the intended beneficiaries.

As for the second defect; namely, underutilization, the academy is aware that a number of conditions contributed to it. One of the foremost was the basis of eligibility. The academy strongly recommends that in the determination of eligibility, medical expense as well as resources should be taken into account. For it is the academy's belief that illness should not impoverish.

Shortly after MAA was enacted, the academy recommended that the Federal statute should provide that MAA, together with all other medical programs that were being or were to be administered by welfare departments in States should be transferred to health departments or State agencies for medical care in which physicians would be in authority and control. In this transfer of authority it should be emphasized that determination of eligibility should also be under the authority of physicians. Events have borne out the need for this action. To the academy it seems no more logical to have social welfare administering medical programs than it would be for health departments to be administering welfare programs. Yet, H.R. 6675 expands, consolidates, and entrenches medica

programs under welfare departments. In the opinion of the academy, this is a most unwise step.

The academy therefore reaffirms its recommendation that all medical and health care programs should be unified under medical administration. Policy and operation of these programs should be the responsibility of medical administration in health departments or medical care agencies.

The New York Academy of Medicine strongly urges your consideration of these recommendations and their incorporation in H.R. 6675.

Very sincerely yours,

CLARENCE E. DE LA CHAPELLE,
Vice President.

HOUSE OF REPRESENTATIVES,
Washington, D.C., May 12, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
2227 New Senate Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: I regret that it has not been possible for me to appear before the Senate Finance Committee to testify in favor of S. 1125 and H.R. 2465, to amend the Social Security Act.

However, I do want the committee to know that I am strongly in favor of amending H.R. 6675, to provide that a beneficiary shall not lose his or her entitlement to social security benefits by reason of marriage or remarriage which occurs after the age of 62.

I am sure there would not be a large number of cases in this category but I do feel that an individual is entitled to social security benefits after the age of 62, regardless of whether or not they marry. Ofttimes such benefits are the sole income for the new couple who are unable to obtain lucrative employment.

I am sorry this amendment was not inserted in H.R. 6675 by the House Ways and Means Committee but I respectfully urge your committee to adopt the provisions of H.R. 2465 and I am confident that the House would go along with this change.

Thank you for your consideration in this matter, and with warmest regards, I am

Sincerely,

SAMUEL N. FRIEDEL, *Member of Congress.*

STATE OF MICHIGAN,
CRIPPLED CHILDREN COMMISSION,
Lansing, Mich., May 5, 1965.

Hon. PHILIP A. HART,
U.S. Senator,
Senate Office Building,
Washington, D.C.

DEAR SENATOR HART: I am writing in regard to H.R. 6675. Section 1901 of the bill provides for medical assistance on behalf of families with dependent children. Section 1902 provides that the administration of this medical assistance shall be the responsibility of the State agency which administers health insurance for the aged. In Michigan this is the State department of social welfare.

The Michigan Crippled Children Commission urges that the bill be amended so that section 1902 would allow the State an option as to which State agency will administer this part of the program.

Since 1927, the Michigan Crippled Children Commission has provided medical care to children of indigent and medically indigent families. This care is provided under the Afflicted Children's Act of the State of Michigan. The Governor has approved a budget request of $5,400,000 for this purpose for the next fiscal year. H.R. 6675 would appear to require that care of children from medically indigent families would become the responsibility of the department of social welfare if Federal funds are accepted for this program.

The care provided by the commission is medically administered. The director of the commission is a physician with training and experience in public health. He is assisted by five physicians who serve as medical coordinators for regions of the State. They have direct contact with the physicians who care for the children and have access to the children when they are hospitalized. They also

work with local health departments who provide case finding and followup services. Because of this, we believe that we are able to influence quality of care to a greater degree than if the program were administered by a welfare agency.

Our work is strengthened by the fact that we also administer the State crippled children's program. There is transfer back and forth between the two programs and we believe that the care of acutely ill and chronically ill children by one agency strengthens services to both.

We are also concerned that if our program becomes welfare directed its services would be limited to children of indigent families, and the children of medically indigent families, whom we now reach, would no longer be served.

I would appreciate anything you can do to have section 1902 of H.R. 6675 amended so that the decision as to which agency would administer medical assistance to families with dependent children could be made at the State level.

Either I or Dr. Rice, the director of the commission, would be glad to meet with you to discuss this problem or send you any additional information you would like to have.

Sincerely,

MARTIN FLEMING, *Chairman.*

MISSOURI STATE MEDICAL ASSOCIATION,
St. Louis, Mo., May 11, 1865.

Senator HARRY BYRD,
Chairman, Finance Committee of the Senate, Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: On behalf of the nearly 4,000 physician members of the Missouri State Medical Association, I wish respectfully to register opposition to H.R. 6675 now under consideration by your committee, with regard to the proposal for a system of health care benefits under social security.

As physicians who daily serve the needs of the sick, we are seriously concerned about the adverse effects this proposal would have on our patients and the public in general. We feel it is a definite step toward interference with, if not control of, the important personal relationships between the patient and his physician, the hospital, and the other health personnel necessary for his care. We feel this approach, tying health care services to the social security system to provide benefits for all regardless of need, is unnecessary, far too costly, and a dangerous departure from the traditional and proven American philosophy of independence whenever possible and assistance when necessary.

We are not unmindful of the fact that some of our elderly do face difficulty in financing health care. We favor and have supported providing help where help is needed. The Kerr-Mills law has given us the major vehicle with which to do this and Kerr-Mills programs can and are working throughout the Nation to solve these problems. In opposition to H.R. 6675, we favor strengthening the Kerr-Mills law in this session of Congress, and are supporting the further expansion of our State program by the legislature here in Missouri.

In some aspects, of course, H.R. 6675 goes beyond provision of a social security-based program of health care for the elderly. One of these is the inclusion of self-employed physicians under the social security retirement program. This, too, the doctors of Missouri oppose, since physicians generally feel capable of providing for their own later years, and in most cases continue to serve their patients beyond the usual retirement age.

Finally, I would like to add a word about the inclusion of the professional services of physicians in the specialties of radiology, pathology, anesthesia and physiatry in the "voluntary" section of H.R. 6675, the section dealing with insurance for physicians' services. Although we emphasize our opposition to the health care proposal as a whole, it is entirely proper that the services of these specialties be classified with those of all other physicians. It would be entirely improper to classify them as hospital services.

The personal services given by the physician in the practice of radiology, pathology, anesthesia or physiatry are professional medical services. They are not institutional services, hospital or otherwise. They are human services made possible only by the training, knowledge, judgment and skill of the physician and they should be classified as such.

In view of the magnitude of the dangers inherent in the proposal, the physicians of Missouri urge that the social security health care provisions of

H.R. 6675 be rejected by the Finance Committee of the Senate and hope, instead, that the committee would call for expansion of the Kerr-Mills law.

Sincerely yours,

PAUL R. WHITENER, M.D.,
President.

LOCAL JOINT EXECUTIVE BOARD OF NEW YORK CITY,
HOTEL AND RESTAURANT EMPLOYEES AND BARTENDERS
INTERNATIONAL UNION, AFL–CIO,
New York, N.Y., May 10, 1965.

Senator HARRY F. BYRD,
Chairman Senate Finance Committee, Senate Office Building,
Washington, D.C.

DEAR SIR: On behalf of the 70,000 members of the Local Joint Executive Board of New York City, Hotel and Restaurant Employees and Bartenders International Union, AFL–CIO, and of the 12,000 captains, waiters, waitresses, busboys, and other dining room employees represented by Dining Room Employees Union, Local 1, an affiliate, we urgently appeal to you to approve section 205 of S. 1, as passed by the House of Representatives. Section 205 proposes to right a wrong which has harmed tipped employees for many years, for this type of employee tips count as wages for withholding tax purposes but don't count as wages for social security purposes. As a result, upon retirement these workers qualify for social security benefits substantially inferior to those of other workers who pay the same taxes. The difference in the rate of benefits may mean the different between economic survival and destitution in old age. The same applies to the survivors, the widows and the orphans, when the head of the family dies.

In connection with this appeal we respectfully wish to bring to your attention the following:

1. The opposition to this bill comes almost entirely from employers. However, a considerable number of employers have expressed support for this bill out of a sense of fairness toward their employees.

2. A small number of employees have been induced to write to your committee in opposition to the bill. This is the result of a propaganda campaign launched by the National Restaurant Association and similar employer groups. This propaganda is a mixture of deception and coercion.

For instance, waiters are warned that if the bill passes they will have to pay higher income taxes. This is not true. The only difference will be that waiters will pay taxes on tips on a pay-as-you-go basis as they now do on the wage portion of their earnings. Waiters and other tipped employees are also told that under the provisions of section 205 they will have to empty their pockets in the presence of proprietors or managers, every night before going home; another glaring untruth.

Consequently isolated expressions of employees' opposition should not be regarded as representative of waiters and other tipped employees as a class.

3. The opposition to this bill is based on a complaint of too much bookkeeping and excessive cost. As to bookkeeping the complaint is grossly exaggerated. Surely a bit of bookkeeping is no reason to deprive so many workers of such vital benefits. As to cost, the additional social security taxes involved will be no higher and no lower than every other employer pays. As a matter of fact employers of tipped employees have enjoyed an advantage over other employers for many years.

4. The suggestion has been made by the opponents that waiters be treated as self-employed persons. This is a contradiction in terms of an absurdity. Waiters are not self-employed; they work for employers who pay them wages, regulate their hours of work, hire or fire them, and decide their conditions of employment. The ridiculous attempt to classify them as self-employed has only one purpose, to shift the entire cost of social security on the employees.

5. Tips have been recognized as wages for social security purposes for certain categories of waiters for several years. These are waiters whose tips are fixed in an agreement between the employer and the guest and are paid by the guest to the employer and by the employer to the waiter. Why not cover all waiters?

Hundreds of thousands of waiters and other tipped employees throughout the country look up to your committee for justice in this matter. You have it in your hands to help these workers and their families enjoy the blessings of our demo-

cratic society as they meet its obligations. Please undo this injustice and grant to these hard-working citizens the same rights as are enjoyed by all other American workers under the Social Security Act. Approve section 205 of S. 1.

Sincerely,

DAVID SIEGAL,
President, Joint Board and President, Local 1.
A. SUSI,
Secretary-Treasurer, Joint Board.
E. SARNI ZUCCA,
Secretary, Local 1.

SANTA FE, N. MEX., *May 12, 1965.*

Senator HARRY BYRD,
Senate Office Building, Washington, D.C.:

The House of Delegates of the New Mexico Medical Society this date voted unanimously its opposition of coverage of professional services of certain medical specialists under title 1 of H.R. 6675.

OMAR LEGANT, M.D.,
President, New Mexico Medical Society.

STATEMENT OF S. COOPER DAWSON, JR.; CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE OF AMERICAN MOTOR HOTEL ASSOCIATION

My name is S. Cooper Dawson, Jr.; chairman of the Governmental Affairs Committee of the American Motor Hotel Association, the national trade association of the motel industry of the United States. We have 42 affiliated State associations with a membership of about 10,000 motels.

This statement is being filed following testimony by Leslie W. Scott of the Government Affairs Committee of the National Restaurant Association presented to the Senate Finance Committee on Tuesday, May 18, 1965. The position of the motel industry of the Nation regarding section 313 of H.R. 6675 is almost identical with that of the restaurant industry.

If section 313 is enacted; motel operators will, for the first time, be required by law to withhold and pay from funds over which the employer never has possession, custody or control—and of which he does not even have knowledge.

The provisions of section 313 of H.R. 6675 requires that employees report their tips in writing to their employers at regular intervals probably as often as every week. It requires employers to record social security and Federal income taxes due on tips reported from the wages to the employee. The employer is required to match the social security contribution of each of his employees. Some motel employees are in the nontip category. A great number, however, are tipped employees especially where motels operate restaurants, bars, and offer facilities for social and recreational events. We have contacted our State associations and made spot checks with hundreds of motels over the country and they are almost unanimous in their objection to section 313 of H.R. 6675 for the following reasons:

(*1*) *Employee morale would suffer.*—Employees will resent reporting their tips to their employer. They often feel the "boss" has a hostile interest in the subject of tips because in their minds, if the employer knew how much tips amounted to, he might try to reduce wages. Also, many employees consider the amount of their tips a completely personal matter. They won't even discuss tips with fellow employees or even their families. The amount of tips is one of the best kept secrets of our industries. Even the Government often has trouble discovering the amount of tip income and the Government is not dependent on the waiter's good will for its continued success. Our people are dependent upon that good will and we do not want to invade this area of their privacy. Employees know they must now report all income to the Government. This they understand. They will not understand why they have to report tips to their employer.

(*2*) *Smaller paychecks mean lower morale.*—For many employees, tax on tips means a tax receipt instead of a paycheck. This is because their tips greatly exceed wages. For most tipped employees, tax on tips means at least double the amount presently withheld. A person with weekly wages and tips of $40 each now has $5.35 withheld. Enact tax on tips and this goes to $12.98 weekly next

year; more than double taken out. Tips vary but a paycheck is steady. It can be relied on. But take too much money out of it to pay taxes and the paycheck loses its significance. On payday the employee forgets his tips. Give him a low-paycheck and morale drops. Low morale can mean low sales.

(3) *Pressure on employer to pay all taxes.*—The employee gets accustomed to a certain paycheck. If it gets smaller, he thinks he is getting paid less money. He will want the employer to reimburse him for what he loses in extra taxes. The employees do not want to lose any money. When they pay extra taxes they will want extra income. They will ask for more wage to cover the extra withholding. Many will quit if they fail to get it. In any case, the pressures for higher wages will be great if tax on tips passes. Employees want a substantial paycheck and a substantial raise in pay will be required to keep take-home pay up if taxes on tips passes. This will be the start of a campaign to have employers pay all taxes because taxes would come from a fund (wages) completely unrelated to the income taxed (tips).

(4) *Tax on tips is expensive.*—Even without pay raises to cover taxes, tax on tips is expensive. If tips reported amount to 15 percent of sales, section 313 of H.R. 6675 will immediately eat up over 13 percent of the profit of motels where tipping is practiced. This is only the direct cost. Consider not only the indirect cost of higher wages but also the cost of administering the Government's collection function. The bookkeeping burden would be tremendous. Many records would have to be kept. Automated payroll processing would, in all likelihood, be impossible. This tremendous additional bookkeeping cost will also cut deeply into profits—and there will be no corresponding increase in productivity.

(5) *Employers cannot control this cost.*—You can fix how much you are willing to pay for food or labor or rent but you cannot fix how much you would be willing to pay for tax on tips. Such a tremendous tax liability would be imposed on a basis of funds over which the employer has neither custody, possession, or control. This would be a new concept to our law and a dangerous one. Employers have no knowledge of the amount of tips received. They would thus be entirely at the mercy of their employees as to the amount of tips reported. Older employees could report high tips hoping to improve their retirement earnings. The employer could not question the amount reported but he would have to match the social security tax due on what was reported. We have already shown what this can cost. This cost is too high to be kept from the employer's control yet there is no way for him to control it.

(6) *Credit for tips is possible now.*—By agreement employers and employees can provide for social security credit on reported tip income today. Also a labor contract now in operation in New York City gives social security credit for tips on an estimate of $1 per hour. The Government accepts this estimate. Nothing in our law prevented the Social Security Administration from allowing tips to count for social security purposes. It elected to promulgate a regulation excluding tip income from credit. Now the Social Security Administration wants a law enacted. One's imagination cannot be strained to call tips wages. A law is needed.

(7) *Tips are like self-employment income.*—Tips are no more wages than interest on a savings account or rental of a home. Tips are a different kind of income than wages. Wages are something you get from your employer. Tips come from customers. Tips are a direct payment for a special personal service rendered. Wages are for doing the work; tips for doing it well. Give poor service and the employee expects to suffer a direct personal financial loss much like the operator of a business. Tips are most nearly like self-employment and not precisely like anything else we know but most nearly like self-employment income. To give tips this treatment would cost employees only about $1.75 more per week in taxes. This is a small price to pay for doing things as they should be done according to reason and good conscience.

Tips can be counted for social security purposes without any changes in existing law. To provide the most fair, practical, and equitable solution to this tip problem would require a change in the law. That change would be to give tipped employees the same benefits that are now given certain other independent contractors. This would enable them to treat tips as self-employment income.

We respectfully urge that you eliminate section 313 from H.R. 6675 and provide for taxing tip income as a self-employment feature.

NEBRASKA STATE MEDICAL ASSOCIATION,
Lincoln, Nebr., May 10, 1965.

Hon. HARRY BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The enclosed resolutions regarding H.R. 6675, were passed unanimously by the House of Delegates of the Nebraska State Medical Association in session on Wednesday, April 28, 1965.

The house has directed that these resolutions be forwarded to you and urges that the contents of these resolutions be implemented as they relate to H.R. 6675.

Sincerely yours,

KENNETH NEFF, *Executive Secretary.*

RESOLUTION

Whereas the voluntary supplemental health insurance plan and social security amendments, H.R. 6675, has passed the House of Representatives and is now before the U.S. Senate Finance Committee for public hearings and consideration; and

Whereas the Nebraska State Medical Association is opposed to the principle of Federal Government compulsory health-care financing through payroll taxes in the social security system; and

Whereas the American Medical Association, the American College of Radiology, the American Academy of Physical Medicine & Rehabilitation, and the College of American Pathologists are on record declaring that the specialties of radiology, pathology, anesthesiology, and physiatry are in their entirety the practice of medicine and are not hospital services; and

Whereas the inclusion of these specialties in the practice of medicine as hospital services would result in nonmedical control of these specialties which in turn would adversely affect the quality of health care provided to the people of the United States: Be it therefore

Resolved, That the Nebraska State Medical Association, through its house of delegates assembled in annual session, does hereby oppose any amendment to H.R. 6675 or similar legislation which would include as hospital services physicians services including the above specialties; and be it hereby further

Resolved, That copies of this resolution be sent to Senators Carl T. Curtis and Roman Hruska; and to Senator Harry Byrd, chairman, Senate Finance Committee; and Congressmen Clair Callan, Glenn Cunningham, and Dave Martin; and to Congressman Wilbur Mills, chairman of the House Ways and Means Committee.

Passed by the House of Delegates, Nebraska State Medical Association on April 28, 1965.

RESOLUTION

Whereas many provisions of H.R. 6675 and particularly those listed below socializes a portion of the practice of medicine and, if enacted, would be a powerful force to inevitably and completely socialize medicine; and

Whereas the people of Nebraska are unalterably opposed to socialized medicine; and

Whereas the elderly who are in need of health care assistance already have a mechanism for obtaining needed assistance through present local, State, and Federal programs: Now, therefore, be it hereby

Resolved, That the Nebraska State Medical Association urges the Senate of the United States in considering H.R. 6675 to:

1. Delete those provisions from the bill which provides hospitalization, nursing home and related care for everyone over 65, regardless of need, financed by increased payroll taxes under social security.

2. Delete those provisions of the bill referred to as "Part B—Supplementary Health Insurance Benefits for the Aged" which would put the Government in the "insurance business" for physicians services for any person over 65 regardless of need.

3. That the Senate provide for any Government assistance to be administered through a State authority with Federal participation being limited to providing Federal matching funds.

4. That the Senate provide for any Government assistance to be based upon need as determined locally by a simple income certification; and

5. Delete compulsory participation of physicians in old-age, survivors, and disability insurance; and be it hereby further

Resolved, That copies of this resolution be sent to Senators Carl T. Curtis and Roman Hruska, of Nebraska; and to Senator Harry Byrd, chairman of the Senate Finance Committee; and to Congressmen Clair Callan; Glenn Cunningham, and David Martin of Nebraska; and to Congressman Wilbur Mills, chairman of the House Ways and Means Committee.

Passed by the house of delegates, Nebraska State Medical Association, on April 28, 1965.

STATEMENT OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS

Mr. Chairman and members of the committee, we are pleased to have this opportunity of submitting testimony against the Mills bill, H.R. 6675.

The Association of American Physicians & Surgeons represents ethical physicians in medical economics, public relations, legislation, and freedom. Our objective of "freedom" can be defined by stating that we oppose the socialization of all segments of the economy just as vigorously as we oppose socialized medicine. Eligibility for membership in the American Medical Association is prerequisite for membership in AAPS.

We oppose H.R. 6675 because:

1. There is no need for a Government financed and controlled program of hospitalization and medical care for the aged. According to the Health Insurance Institute, health insurance for those over 65 years of age is now leading all other areas of health insurance in terms of growth. By 1970, insurance actuaries estimate that the coverage of the aged will rise to between 89 and 90 percent. The indigent aged now receive medical care without charge by the Nation's physicians—as physicians always have done.

2. H.R. 6675 proposes a program of socialized hospitalization and medical care for the aged. Since the Government will provide and control hospitalization services and the financing thereof; since the Government will control the medical services offered to the aged by financing the subsidization of the insurance carriers responsible therefor; the program is one of outright, unadulterated socialism.

3. Historical experience of socialized medical care in other countries indisputably proves that hospital and medical services have always deteriorated and, therefore, it must be concluded that the socialized hospitalization and medical care program, provided in H.R. 6675, will greatly reduce the quality of care delivered to our people.

4. It will destroy the vitally important patient-physician relationship which is so essential to the delivery of quality medical care. This will be true despite contrary statements of proponents as will be pointed out subsequently.

5. The Honorable Durward G. Hall, U.S. Representative from Missouri, a student of the legislation and well qualified in his dual capacity as a doctor of medicine and a legislator to appraise the legislation, on April 9, 1965, in Chicago pointed out some of the factors in H.R. 6675 which clearly point to a deterioration of medical care:

(*a*) The basis for quality medical care is the voluntary relationship between the doctor and his patient. This would begin to disappear as the Government supplants the individual as the purchaser of health services.

An obvious attempt has been made in this legislation to conceal the grant of power which would be extended to the Secretary of Health, Education, and Welfare, to interfere with administration and medical practice in participating hospitals. But the power is in the bill, and its use by Government employees in carrying out their responsibilities toward the expenditure of Government funds cannot be doubted.

The result would inescapably be third-party intrusion in the practice of medicine. The physician's judgment would be open to question by others not responsible for the patient's well-being. His diagnostic and therapeutic decisions would be subject to disapproval by those controlling the expenditure of tax money. Paradoxically, the physician's cooperation is absolutely necessary for proper functioning of the law and certainly to avoid the abuse factor.

(*b*) As the Government begins to fix prices for services rendered—as indeed it must to protect the public purse—financial incentive would begin to melt away.

(c) The incentive derived from competition with one's peers, invariably the spark which ignites the flame of creative progress, would also fail, since rivalry would be eliminated, by virtue of centralized direction, be it practice or all-important bedside research.

(d) As physicians and health facilities become more and more subject to intervention in their work by lay government employees, a decline of professionalism will be certain.

(e) The overutilization and abuse of a "free" service, to which everyone had a "right," would result in increasing harassment, which could not fail to lead to a form of medicine abuse factor and bed occupancy alien to these shores—medicine on an assembly-line basis.

(f) Quality medicine would be dealt a further blow by the loss of able entrants in the health field, because young men, viewing a profession under partial or total Government domination, could be expected to seek careers in other fields. This has been the rule in other countries.

6. Congressman Hall, who has carefully studied this legislation and analyzed its implications, stated on April 9, 1965, that "Its true nature is one of subsidy, coercion, and control. The Supreme Court, in 1942 in *Wickard* v. *Filburn*, said: 'It is hardly lack of due process of the Government to regulate that which it subsidizes.' Despite the bold and brazen denial that authority is not granted to control the practice of medicine or any agency providing health services, the clever, fine print, fails to conceal the clear hand of Central Government control. 'As approved by the Secretary,' 'in accordance with standards prescribed by the Secretary,' 'as the Secretary may find necessary,' and, 'a utilization review plan of a hospital * * * shall be considered sufficient * * * if it provides * * * notification to the individual, and his attending physician that any further stay in the institution is not medically necessary,' are the words (in plain and naked language), of control."

7. By offering supplemental hospitalization insurance at $3 per month, this program (H.R. 6675) presents a very grave threat to the survival of private insurance carriers. These are certain to experience a high cancellation rate when those privately insured eligibles choose cutrate Government insurance with premiums withheld from social security gratuities. A very high percentage of those eligible for benefits under H.R. 6675 are now covered by some amount of private insurance. Even Mr. Mills himself admits this cancellation threat to the existing carriers.

8. By making the combination of benefits under workman's compensation and social security so much more financially rewarding than wages of regular employment, H.R. 6675 will undermine the rehabilitation efforts of physicians and compensation insurance carriers.

9. Implementation of the socialized hospitalization and medical care provisions of H.R. 6675 would be the forerunner of a complete program of socialized hospitalization and medical care for all citizens regardless of age. It is only reasonable to presume that the millions of employed who will be taxed to provide benefits for others (the aged) eventually will demand that they receive their share of benefits in return for the tax money which will be extracted from them. In view of repeated statements by such men as Reuther and Forand that this is only the beginning, pious denials by others mean nothing.

10. It has been estimated that the cost of H.R. 6675 for the first year will amount to $30 for every man, woman, and child in the Nation. It has been further estimated that a young person just now starting to pay taxes into the social security system can expect to pay, chiefly as a result of H.R. 6675 and anticipated amendments, at least $20,000 before becoming eligible for any benefits whatsoever. The extraction of this great sum from the income of our workers, when their needs are greatest, will impair their ability to provide food, clothing, housing, and education for their families. Deprivation in these areas is bound to be reflected in the general state of mental and physical health.

11. H.R. 6675 calls for the compulsory inclusion of physicians in the social security system. This is discriminatory taxation because only 5 percent of physicians retire and thus millions of dollars in taxes would be taken by force from physicians and, in return, they would receive little or no benefits.

Members of the Association of American Physicians & Surgeons believe that the American people of all ages (not only the aged) should receive the highest quality of medical care it is possible to render regardless of the ability of the patient to pay for such care. Under the U.S. system of private practice—with freedom of choice of physician and patient kept inviolate—the American people

have been and are receiving the finest medical care in all the world. No other country has health records to match those of the United States. To our knowledge—as previously pointed out—no individual is being denied quality medical care because of inability to pay for it—regardless of age. This is further indication that there is no demonstrated need for the ill-advised provisions of H.R. 6675.

To destroy this system of medical care, which has provided the American people with the highest quality of medical care available anywhere in the world, by imposing a system of compulsory socialized medicine on first the aged, and then soon inevitably the entire population, would be a stark tragedy for the Nation.

For these reasons, and for many others presented to this committee, we urge committee members to stand unalterably opposed to the Mills bill (H.R. 6675) and back their convictions with their votes.

Respectfully submitted.

E. E. ANTHONY, M.D., *President.*

THE U.S. PHARMACOPEIA,
New York, N.Y., May 10, 1965.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: We are pleased to respond to your invitation of April 29 to comment on the section 1861(t) of H.R. 6675 wherein the terms "drugs" and "biologicals" are defined.

We have studied the section in question and other relevant parts of the bill with care and in relation to their bearing on the intended purposes of the proposed legislation as a whole. We have tried to envisage how the definitions might serve to implement the intent of the Congress and we offer the following comments on the provisions with special reference to the U.S. Pharmacopeia, for which the abbreviation "U.S.P." is generally used. Actually, the U.S.P. and the National Formulary may be considered together since they are both cited as "official compendia" in the Food, Drug and Cosmetic Act of 1938. Furthermore, they are complementary in the sense that their respective areas of coverage do not overlap, and there is basically little difference in the criteria by which the choices are made of the articles listed in each compendium. The Pharmacopeia and the National Formulary are revised completely every 5 years. Supplements, usually 2 or 3, appear in the interval between publications of each new U.S.P. revision.

From its inception in 1820, the Pharmacopeia has adhered with constancy to three objectives: (1) to select from the drugs in current use those that are well understood and established as representing the best teaching and practice of medicine; (2) to standardize the names of drugs, and (3) to provide standards of strength and purity for the selected articles. In a large measure, the National Formulary has the same objectives in that it lists such articles as are considered valuable in the practice of medicine but not included in the Pharmacopeia.

The advisory panels of physicians which aid the U.S.P. Committee of Revision in making its selection of U.S.P. drugs include experts from practically every specialty of medicine. Each expert is highly respected for his knowledge of medicine and the care of the ill. It is the high standing of these experts that lends weight to the judgment that they render in respect to the choice of drugs that go into the U.S. Pharmacopeia.

The Pharmacopeia and the National Formulary, therefore, are useful as sources of selective lists of drugs and this fact has rather wide application. Surveys have shown that U.S.P. recognition is by far the largest single factor in determining that a drug will be listed in a hospital formulary. On the other hand, it has been a source of some embarrassment to the U.S.P. in the past to have its list used to determine where an article may be sold, i.e., whether restricted to sale from a pharmacy or permitted to be sold from a grocery store.

It has come to our attention that misgivings have been expressed over possible shortcomings of these definitions in H.R. 6675 from the standpoint of allowing payment for preparations that constitute mixtures of drugs, and for drugs that have been recently introduced. It is quite true that the U.S.P. recognizes but few mixtures; actually, only four mixtures of drugs are listed at present. These are rational mixtures upon which physicians agree; specifically they represent a formula of 10 vitamins in the amounts established by the National Research Council as the minimum daily requirements, and combinations, re-

spectively, of two forms of the antibiotic streptomycin, of equal amounts of three sulfa drugs which are safer when so combined, and of caffeine and sodium benzoate which form a soluble mixture that can be injected intravenously.

The physicians that make up the U.S.P. advisory panels generally frown on the use of mixtures of fixed proportions on the grounds that they fail to meet the individual needs of patients. The basis for the development and introduction of a mixture of drugs does not invariably include considerations of convenience or improved therapy. What makes their use important to the drug industry is the fact that each is unique and thus can be obtained as a rule only from a single source. This feature confers on mixtures certain obvious advantages from the producer's standpoint with respect to their promotion and distribution.

As for including new drugs, the timelag between the introduction of a drug and its general acceptance and recognition varies and is bound to be shorter in the future as a result of the Drug Amendments of 1962. That is, whereas in the past there have been examples of drugs having been discovered and placed on the market within a year (for example, oxytetracycline hydrochloride, which was discovered in 1950 and marketed later the same year under the brand name Terramycin), all drugs now require longer study. In consequence, the drugs will be much better known and understood by the time they reach the market. This will operate to the end that drugs of merit will be recognized much more promptly both by a hospital formulary committees generally and the U.S.P.

A source of concern, however, is the unavoidable delay between the time a drug is "admitted" to the U.S.P. by vote of the U.S.P. Revision Committee and the time that it becomes "official" through publication of U.S.P. tests and standards for it. Also, a reasonable time, varying from a few weeks to 6 months, must be allowed after publication before the standards take effect, i.e., the date after which all interstate shipments must meet the U.S.P. standards in order to comply with the Food, Drug, and Cosmetic Act. The drug chlorothiazide affords an excellent example of the problem concerned here. Because the discovery of chlorothiazide was a genuine "breakthrough" in therapy, the drug was subjected to long and thorough study in the clinic before the customary and recognized legal steps were initiated to put it on the market. In consequence, chlorothiazide was fairly well known and established by the time it went on sale about January 1, 1958. In view of this, it was "admitted" to the U.S.P. at a U.S.P. meeting held on January 25, 1958, a fact that was promptly made public. However, U.S.P. standards that could be considered "adequate" within the meaning of section 501(b) of the Food, Drug, and Cosmetic Act were not immediately available and could not be included in the U.S.P. Supplement that appeared December 15, 1958. Standards were included in the next revision that appeared in March 1960; however, strictly speaking, chlorothiazide did not become "official" until October 1, 1960, the effective date of the 16th Revision of the Pharmacopeia. This was some 32 months after the drug had actually been "admitted" to the Pharmacopeia.

The officials of hospitalization plans meet this problem of timelag by allowing payment for U.S.P. drugs from the time the latter have been voted admission to the Pharmacopeia. This suggests that the difficulties envisaged with respect to the present draft of section 186(t) of H.R. 6675 might be overcome largely by substituting the phrase "admitted to" for "included in" and making other minor changes as needed. The definition might then read (the new wording being italicized):

"(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 *admitted to* the United States Pharmacopeia or the National Formulary, or *listed* in * * *."

We hope that these comments and suggestions will be regarded as constructive and will receive consideration by your committee in its deliberations.

Respectfully yours,

LLOYD C. MILLER, Ph. D.,
Director of Revision.

STATEMENT OF MARK M. JONES, PRESIDENT, NATIONAL ECONOMIC COUNCIL, INC.

MEDICARE—A CRITICAL ASSESSMENT

This statement is submitted on behalf of the National Economic Council. It is intended to present a critical assessment of H.R. 6675, including its nature and its prospective impact. It is based upon material from numerous sources. It

may sound negative because the assessment yields little that is favorable to the bill. It indicates that the medicare idea is unsound and unworkable; that it is illegal, unconstitutional, and subversive. In other words, it is not only a gigantic fraud, but will produce a Frankenstein monster without parallel.

About the only hope left after such a review is that maybe and if there is anything in the pendulum theory of history, this extreme of extremes may more quickly start a swing back toward sanity and responsibility.

This statement is arranged to present specific points with respect to the bill in four categories, as follows:

What it is not.
What it is.
Its effects.
What it ignores.

WHAT IT IS NOT

Although 206 pages are used for H.R. 6675, and these are an almost impenetrable jumble of words, the following are some of the things medicare is not:

It is not what it is represented to be.
It is not what it is believed to be.
It is not insurance.
It is not needed.
It is not wanted, except by politicians, economic illiterates, and the indigent fringe.
It is not workable.
It is not medical care, but is limited to temporary hospital and nursing home care.

WHAT IT IS

Medicare is a major feature of the plan now well advanced toward establishing complete federalization of American life. It is a very important feature serving to round out the structure of executive despotism.

It is to control and regiment your doctor, your hospital, your nursing home, and you. It adds greatly to the forces inducing the development of socialized medicine.

It is a device to federalize the Nation's hospital system by use of Federal tax funds paid to hospitals and nursing homes.

It is a means of making another big subtraction from the tax base together with a forced increase in the nonproductive overhead in which it will result, thus making the national economy more topheavy than ever.

It reflects a supreme contempt for the people on the part of its proponents. This attitude was once given expression by Harry Hopkins when, in referring to the people, he said, "They are too damn' dumb to understand."

It is an attempt to tell the States how to manage their financial affairs, particularly because of the provision requiring State contributions for medical care of the needy.

It is one of the most gigantic and cruel frauds ever perpetrated on a people.

ITS EFFECTS

The thinking behind medicare already has brought us close to being a nation of moochers and panhandlers. We are told that the number of perverts and dope addicts is increasing rapidly. The crime rate also is rising rapidly.

Medicare would provide a slick new way to put over increased taxation.

Ultimately, it would deprive you of your right to choose your own doctor.

It would have immeasurably disastrous effects upon the hundreds of existing health insurance businesses which operate successfully on a going-concern basis, as well as upon the countless associations of mutual or cooperative nature also operating in this field.

It would slow down and ultimately stop scientific progress in medicine and medical care.

It would become one of the most outstanding examples of politicalization of the economy at the expense of productivity among the many others.

It is estimated that medicare would cost $6.6 billion the first year.

The elephantiasis onto which the medicare monstrosity would be grafted (Health, Education, and Welfare) long since has passed the point of diminishing returns so far as value and efficiency are concerned. Launched in 1937, on the solemn assurance that social security positively would solve the aging problem:

it has degenerated into a parasitic bureaucracy of 82,740 as of November 1964. Under medicare, will it have 120,000 at the end of the first year, or 150,000?

It would place our already financially unsound social security in additional jeopardy. Social security now has an unfunded liability or deficit of $320 billion. To this, medicare, upon taking effect, would add an estimated $25 billion to $60 billion because some 16 million persons will automatically become eligible for benefits, even though they have never paid any tax money to finance them.

It would soon increase the total chargeable to it; hospital costs have been rising at an average of 7 percent a year for the past 10 years.

It would require that a great proportion of the increased tax burden be carried by those least able to bear it.

It would require many employees, taxed at the rate of 5.2 percent by 1971, to pay more social security taxes than income taxes.

It would force its so-called medicare on everyone (even the millions not now covered by social security) and disregard the fact that at least 65 percent of the aged already have made all necessary provision for themselves.

It not only would increase the social security tax of every wage earner, but at the same time would reduce the purchasing power of his income.

It would increase prices and become one of the mightiest of all inflationary forces among the many. It would accelerate the decline in the purchasing power of the dollar, recently down to 35.6 cents in comparison with 1932.

It would put Government into competition with citizens and private enterprise in a mighty way, and both by reason of its colossal proportions and the Gresham effect on enterprise of Government services, would steadily drive out incentives for private initiative and build up an inefficient monopoly of proportions without precedent.

It would also subtract great amounts from the tax base by reason of the above.

It would be one more package of devices of degenerative character which would enlarge and accelerate the already well-advanced trend toward standardized mediocrity throughout life.

It would have a tremendous impact on the lives of almost all of our people—not just those over 65 who may avail themselves of so-called benefits. The impact on young people would be incalculable because of its unsettling subtraction from economic soundness and stability of the entire economy and because of its automatic curtailment of the scope of their opportunities in life. It would have a similar effect on the middle-aged.

The costs would fall on individuals in the twenties, thirties, forties, and fifties and throughout the years they work until they retire. Passage of this measure not only would raise the rate of tax that must be paid by employees, employers, and self-employed, but it would raise the level of covered wages from the present $4,800 a year to $6,600 a year by 1973.

In the course of his employment until age 65, a young man who will be 21 next January 1, under medicare would pay taxes totaling $15,469.90. If these payments were placed in a savings account paying 4 percent interest compounded quarterly, he would build up fund of $40,658.54 by age 65.

Because of a very liberalized definition of total disability that was slipped into the bill in the House, largely without notice, just before it was ordered reported, it would further weaken the State workmen's compensation laws. Under the proposed law, disability would be paid an insured worker who has been totally disabled for 6 calendar months even though it is expected that he will recover in the foreseeable future. Also, social security benefits would be paid whether or not the disabled worker was receiving State workmen's compensation benefits; in other words, providing dual benefits. As sent to the Senate, the bill also leaves open the question of who will determine the disability and how, and who will determine when the disability ends.

By making Federal benefits available to more people—thousands and thousands would be receiving Federal payments—it would reduce the incentive and desire of States to keep modern or improve their workmen's compensation laws. It would set up endless controversy among the Federal and State bureaucrats. If social security should eventually replace State laws, it is expected ultimately that employers might again be liable for personal suits by injured workers under common law because Federal law does not provide this protection.

In an overall sense, one of medicare's supereffects would be, for those who wish to see, a conclusive demonstration of the folly of the 16th amendment. This was the omission from that amendment of a limitation on the power of

the Federal Government to tax. Parallel to this was the failure to impose a limitation on the power to spend. There is now more than enough evidence to prove to reasonable minds that large-scale spending and taxing by Government can't really work in the interests of the people.

It would have effects that would subject 198 million people to the control and domination of what would be a combination of Frankenstein monster and octopus of elephantine proportions which will serve admirably to accelerate the achievement of Stalin's goal of making capitalism pay for its own funeral.

WHAT IT IGNORES

Medicare ignores the overwhelming evidence of the spread of degeneration through the national economy. Signs of inflation now are apparent on every hand The purpose of building up an executive despotism, for which the social security system was in part designed, included the expectation that the social security card might ultimately be taken from anyone who offended the reigning despot, and thus deprive the offender not only of the opportunity to speak as a free man, but also of the opportunity to work.

It ignores the fact that it is one more delegation of power to the executive branch of the Government, which already is not able even to comprehend the pyramid of powers for which it is responsible as well as the fact that the executive branch is incompetent to manage the duties for which it is already responsible.

It ignores the fact that it is another delegation of power to the executive branch that extends the process of undermining the legislative branch and pushes it still further toward servile impotence.

It ignores the fact that all Government expenditures are overhead expenses of the national economy; that overhead must be regulated with due relation to production and the income of the people; and that disregard of this elementary fact has been one of the principal causes of the decline and fall of previous civilizations.

It ignores the fact that Government expenditures in the United States—Federal, State, and local—are now running at an annual rate in excess of $200 billion; that this total exceeds 50 percent of the real product and is out of all proportion to the essentials for maintaining a going-concern economy.

It ignores the fact that Government spending has been carried on recklessly and without regard for income, with the result that the Federal debt alone is in excess of $320 billion, on which carrying charges are approximately $11 billion a year.

It ignores the fact that a generation of experience has clearly proved that Government management is incompetent, inefficient, indiscriminate, irresponsible, and unreliable.

It ignores the fact that a recent national poll showed that 74 percent of the Nation's adults favor the eldercare proposal of the American Medical Association, and only 14 percent prefer medicare.

How can a vote for medicare by a Member of the House or Senate be anything other than brazen violation of his or her oath of office and an extreme expression of contempt for his or her constituents, the Constitution, and the country?

The whole thing is as dishonest as pouring water into milk.

It could only arise from the moral cancer at the political heart of the Nation.

AMERICAN FARM BUREAU FEDERATION,
Washington, D.C., May 11, 1965.

Subject: H.R. 6675, social security and medicare.

Hon. HARRY F. BYRD,
Chairman, Senate Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: The voting delegates of the American Farm Bureau Federation at their most recent annual meeting in December 1964, adopted the following policy in reference to social security and medicare.

"We are opposed to any increases in social security taxes beyond those already scheduled in the law and to any additional benefits, such as the pro-

posed medical care program, which would require still further increases in taxes. The need for medical insurance should be met by the expansion of private insurance programs."

The medicare proposal as contained in H.R. 6675 takes an unparalleled step toward involving an agency of the Federal Government in the financing and regulation of medical and hospital services and care rendered to individuals.

Here are some of the more important reasons why we are opposed to H.R. 6675.

(1) We think it unsound policy for the Congress to adopt a medical program that will tax the poor to provide, in far too many instances, medical help for persons who have sufficient means to finance their own needs. By establishing an age limit instead of need plus age as the only qualifying criteria for medicare, low-income families will be forced to pay medical expenses for those who could afford to pay their own.

(2) It increases both the rate of tax and the taxable base in order to finance the Government medical program. This is a regressive tax and hits hardest those persons least able to pay.

(3) Further, guaranteeing hospitalization to all persons over 65, regardless of need or ability to pay, will overload the already crowded medical facilities and hospitals.

(4) This legislation, if enacted, will add a new and unnecessary tax load to young wage earners and self-employed persons such as farmers. At a time when farm costs are at a staggering level in relation to cash farm receipts, we find it impossible to support a program that would nearly double the tax a farmer presently pays under the social security program.

We recommend that the Senate Finance Committee reject this proposal.

Please enter this letter as a part of the hearing record.

Sincerely yours,

JOHN C. LYNN,
Legislative Director.

STATEMENT SUBMITTED BY E. B. WHITTEN, DIRECTOR, NATIONAL REHABILITATION ASSOCIATION

THE PROPOSAL

We propose that section 222 of the Social Security Act be amended to permit payment of the cost of vocational rehabilitation services for OASDI beneficiaries from the OASDI trust fund. A proposed amendment accompanies this statement. This proposal was made by the Advisory Council on Social Security in its recent report. It is justified in the following paragraphs.

REHABILITATION POTENTIAL

Many applicants for social security disability benefits have potential for vocational rehabilitation. This potential is present in both denied and allowed cases. It is best revealed by an intensive team evaluation in workshop or other vocationally oriented rehabilitation facility.

Under the regular procedures of the State-Federal vocational rehabilitation program, 39,012 applicants for disability benefits were rehabilitated during a 5-year period ending June 30, 1964; 11,030 of this number were persons for whom disability benefits had been allowed. Beginning with 1,100 in fiscal 1959, the number of allowed cases rehabilitated has been gradually increasing, rising to 3,200 in 1964. On June 30, 1964, about 19,000 applicants were receiving or had been accepted for vocational rehabilitation services under the State-Federal program. Most of these are denied applicants.

The Vocational Rehabilitation Administration has research contracts with Ohio State University, Tulane University, and Kenny Rehabilitation Institute to determine vocational rehabilitation potential through intensive team evaluation. Cases are selected at random from the files and include both allowed and denied cases. The official report of these studies is not yet available, but the following facts have been revealed: 2,500 cases have been evaluated, equally divided between allowed and denied cases. Approximately 35 percent have been found to have sufficient potential for vocational rehabilitation to warrant referral to the State vocational rehabilitation agencies. This is contrasted to 11 percent being referred to vocational rehabilitation without this team evaluation.

The Vocational Rehabilitation Administration estimates that a minimum of 15,000 to 20,000 can be rehabilitated each year, if adequate resources are available. If the temporarily totally disabled become eligible for disability benefits, this number could easily be doubled. It is particularly important that this "temporary" group receive rehabilitation services promptly; otherwise many will become long-term disability cases.

EXPERIENCE OF PRIVATE CARRIERS

Congress might well consider the experience of commercial insurance companies in providing or purchasing rehabilitation services for their beneficiaries. By making rehabilitation services available promptly, Liberty Mutual estimates a saving of $42,000 on medical bills alone on the average spinal injury case. Employee's Mutual estimates a saving of $2.4 to $4.7 million as a result of rehabilitating 27 to 35 paralyzed individuals. Nationwide Mutual has had similar experience with an experimental program. Initiated in connection with workmen's compensation injuries, these rehabilitation programs are now being extended to other beneficiaries, including the victims of automobile accidents. Since insurance companies are frequently liable for long-term medical benefits as well as pensions for permanent disability, their experiences are not directly comparable to what might be expected under the social security program. The main point is clear, however: prompt provision of intensive rehabilitation services saves money for the carriers. It will do the same for the trust fund.

In summary, it might be said that evidence is accumulating that applicants for disability benefits, both the allowed and the denied, have much more vocational rehabilitation potential than was originally thought. Rehabilitation potential is concentrated, of course, largely in applicants who are in the general work age. Evidence is also accumulated to indicate that State vocational rehabilitation agencies can deal effectively with these individuals, but that an intensive team evaluation is required in order to reveal the existence of such potential. This evaluation is important both to the agency which will be expending tax funds to rehabilitate the individual and to the handicapped individual whose morale is lifted immeasurably as the result of finding he has work potential he had not previously recognized.

ADEQUATE FINANCING NOT AVAILABLE

Adequate financing of vocational rehabilitation services for applicants for disability benefits (including intensive evaluation services) cannot be provided under the State-Federal vocational rehabilitation program mechanism without assistance from the trust fund.

The State-Federal vocational rehabilitation program operates under the Vocational Rehabilitation Act, Public Law 565 of the 83d Congress. The definition of a "handicapped individual" under this law is broad, and most of the allowed applicants for disability benefits are probably eligible for services under this act, although many may not be able to benefit substantially. The Federal Government, within sums appropriated by Congress, reimburses State vocational rehabilitation agencies for an average of about 60 percent of the cost of rehabilitation services provided. Federal shares run from 50 percent in the higher income States to 70 percent in the lower income States. The development of vocational rehabilitation services under this program is not uniform.

There is a wide variation in State per capita appropriations for vocational rehabilitation services and, as a result, in the extent and depth of such services. Although State agencies will continue to serve and rehabilitate limited numbers of applicants for disability benefits without additional resources, these agencies cannot be expected to provide on a uniform national basis the services that will be required for this large group of handicapped individuals. In addition, most vocational rehabilitation services under the State-Federal program are provided on the basis of need, which mitigates against prompt comprehensive rehabilitation in many cases. This would not apply to rehabilitation services provided under the amendment to section 222 which we propose.

SAVING TO THE TRUST FUND

Expenditures from the trust fund for vocational rehabilitation services for applicants for disability benefits will result in a net saving to the trust fund.

The Vocational Rehabilitation Administration research contracts have revealed that the cost of rehabilitating an allowed disability beneficiary is about $1,200, which is near the average of all handicapped individuals rehabilitated by the agency. This includes salaries and overhead expenses as well as case service expenditures.

On the average, a disability beneficiary may expect to receive about $9,000 in benefits, if he has no dependents. Beneficiary families, consisting of a disabled worker, his wife, and one or more children, can expect to receive about $17,000 on the average. One successful rehabilitation, therefore, can result in savings in benefit costs of from $8,000 to $16,000. Even if costs of rehabilitation should prove to be considerably more expensive than is predicted, we can still say that the rehabilitated individual will save the trust fund from 5 to 10 times the amount actually spent upon him.

Another way of stating this would be to say that if vocational rehabilitation agencies were able to succeed in rehabilitating not over 1 out of 5 to 10 individuals upon whom they expend the full rehabilitation treatment, this would still mean there would be no loss to the trust fund. Actually, professionals in the field are confident that rehabilitation will be successful in from 40 to 60 percent of the cases carried through to conclusion. This assumes, of course, reasonable criteria for the selection of cases. These figures do not take into account the fact that once rehabilitated the disabled person will actually be paying into the trust fund again through payroll taxes. Most individuals not vocationally rehabilitated will reap rich benefits in terms of ability to care for themselves.

If all of these individuals could be rehabilitated by the State rehabilitation agencies without the use of the trust fund, an argument might be made that the provision of rehabilitation services from the trust fund is substituting expenditures from the trust fund for expenditures from other sources. Since it is clearly impossible that such services be rendered to large numbers of applicants under the present State-Federal mechanism, it becomes evident that the provision of rehabilitation services from the trust fund will be beneficial to the trust fund. In fact, this appears to be the most promising avenue possible for eventually reducing expenditures from the trust fund for disability benefits.

ADMINISTRATION

The provision of vocational rehabilitation services, to applicants for disability benefits with trust fund financing (including intensive team evaluation) can be administered cooperatively by the Vocational Rehabilitation Administration and the Social Security Administration without disturbing the wholesome State-Federal relationships existing between the States and the Social Security Administration and the Vocational Rehabilitation Administration.

The Vocational Rehabilitation Administration and the Social Security Administration have been considering for 2 or 3 years the benefits that might accrue from payment of rehabilitation costs from the trust fund. In so doing, they have consulted with the State rehabilitation agencies, which administer determinations under the existing program, with the National Rehabilitation Association, and others concerned for the rehabilitation of the Nation's disabled people. They have been able to work out a memorandum of agreement on how the two agencies would work together in administering the program. It has been found that there are no difficult barriers to setting up the administrative machinery that would enable this program to go into effect immediately and operate smoothly. State rehabilitation agencies concur in this conclusion. The Social Security Administration would, of course, be responsible for establishing the criteria for the selection of cases to be served. The Vocational Rehabilitation Administration would be responsible for the supervision of the rendition of case services to the individuals. In so doing, they would work within the existing framework of State-Federal relationships, now firmly established and working harmoniously.

SAFEGUARDS

Safeguards can easily be provided in law and regulations to assure an orderly approach in the financing of rehabilitation services from the trust fund.

Everyone who has studied this problem recognizes that payments from the trust fund should start on a small scale and be expanded as experience is gained and results documented. In the beginning years, Congress might consider whether it would be advisable to limit the percentage of the disability benefits trust fund collections that might be expended upon rehabilitation services. The

Social Security Administration and the States will set up criteria for the selection of cases to be served. It seems reasonable that criteria established in the early years would concentrate upon cases for which there is more than a reasonable expectation that vocational rehabilitation will result. As experience is gained, the program can be expanded to include more individuals for whom the expectancy for rehabilitation may be less sure. There appears to be no reason why this program cannot be administered successfully. The important thing is to get it underway. Despite the contribution of research contracts to providing answers to many problems, the real answer will not come until a bold experiment has been made along lines suggested in this statement.

PAYMENT OF COSTS OF REHABILITATION SERVICES FROM TRUST FUNDS

(An amendment to S. 6675)

Section 222 of the Social Security Act is amended by redesignating subsections (b) and (c) as subsections (c) and (d), respectively, and by inserting after subsection (a) the following new subsection:

"COSTS OF REHABILITATION SERVICES CHARGEABLE TO TRUST FUNDS

"(b)(1) For the purpose of making vocational rehabilitation services more readily available to disabled individuals who are (A) entitled to disability insurance benefits under section 223, or (B) in a period of disability under section 216(i), or (C) entitled to child's insurance benefits under section 202(d) after having attained age 18, to the end that savings will result to the trust funds as a result of rehabilitating the maximum number of such individuals into productive activity, there are authorized to be transferred from the trust funds such sums as may be necessary to enable the Secretary to pay the costs of vocational rehabilitation services for such individuals, including necessary costs of administration, except that the total amount transferred from the trust funds under this subsection in any fiscal year may not exceed 2 percent of the benefit payments certified in the preceding year pursuant to section 202(d) for children who have attained age 18 or pursuant to section 223.

"(2) In the case of each State which is willing to do so, such vocational rehabilitation services shall be furnished under a State plan for vocational rehabilitation services which—

"(A) has been approved under section 5 of the Vocational Rehabilitation Act,

"(B) provides that such services will be furnished with reasonable promptness to any such individual in the State to the extent funds provided under this subsection are adequate for the purpose and, in case such funds are not adequate to provide such services to all of them, shows the order to be followed in selecting those to whom such services will be provided, such order to be based on criteria formulated by the Secretary which take into account the relative effect upon the trust funds of providing such services to such individuals, and

"(C) provides that such services will be furnished to any such individual without regard to (i) his citizenship or place of residence, (ii) his need for financial assistance except as provided in regulations of the Secretary in the case of maintenance for an individual living at home while receiving rehabilitation services, or (iii) any order of selection followed under the State plan pursuant to section 5(a)(4) of the Vocational Rehabilitation Act.

"(3) To the extent that vocationl rehabilitation services cannot be provided to any such individual in any State under a plan of such State which meets the requirements of paragraph (2), the Secretary may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals.

"(4) Payments under this subsection may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

"(5) Money paid from the trust funds under this subsection for purposes of providing services to individuals who are entitled to benefits under section 223 or who are within a period of disability under section 216(i) shall be charged

to the Federal Disability Insurance Trust Fund, and all other money paid out from the trust funds under this subsection shall be charged to the Federal Old Age and Survivors Insurance Trust Fund. The Secretary shall determine according to such methods and procedures as he may deem appropriate—

"(A) the total cost of the services provided under this subsection, and

"(B) subject to the provisions of the preceding sentence, the amount of such cost which should be charged to each of such trust funds.

"(6) For the purposes of this subsection the term 'vocational rehabilitation services' shall have the meaning assigned to it in the Vocational Rehabilitation Act, except that such services may be limited in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purposes of this subsection."

STATEMENT BY WILLIAM J. PEEPLES, M.D., COMMISSIONER, MARYLAND DEPARTMENT OF PUBLIC HEALTH, BALTIMORE, MD.

The Maryland Health Department has, for the past 20 years, been in the everyday operation of administering and providing medical care to the indigent and medically indigent public under Maryland's medical care plan. This plan originated as a result of joint action between the Maryland Planning Commission, the Medical and Chirurgical Faculty of the State of Maryland and the Maryland Department of Public Health.

The program provides for inpatient medical care which is unlimited in terms of hospital days and the length of stay depends solely on the medical and surgical needs of the patient. The plan also provides for outpatient care in clinics of recognized general hospitals. The larger part of the program, as far as volume is concerned, involves payment for services of private physicians, who give indigent and medically indigent individuals care in their own offices and the patient's home. Drugs, appliances, and other medical necessities are provided by the program. The program also provides for dental work, prosthesis, restorative types of dentistry and provision for eyeglasses. In addition to the program described, the State of Maryland operates extended aftercare facilities in the form of rehabilitation, chronic disease hospitals, and tuberculosis hospitals. The State health department will, in a short while, begin paying for care in nursing homes throughout Maryland that are licensed by this department. Funds provided to the department of welfare are transferred by contractual agreement to the department of public health to provide support, along with State funds, to the program. This overall comprehensive program extends throughout the State of Maryland and the city of Baltimore.

H.R. 6675 does provide for the acute medical needs of individuals in general hospitals and those who need convalescent care in nursing homes. The bill, however, does not provide for those individuals who may need long-term hospital care and extended periods of care in nursing homes or other types of aftercare facilities. The provision of the bill which provides for 240 visits per year from organized home-care services is probably adequate. We feel, however, that the individual who has, for instance, had an automobile accident with severe skeletal injury, who might be required to remain in a general hospital for several months, would receive only partial protection for this type of long-term injury and resulting disability.

Further, the bill does not provide anything in the way of payment for medication, and only under the insurance title of the bill, is there provision for the payment of physicians.

Under the provisions of H.R. 6675, if an individual went into a general hospital to undergo surgery for a nonmalignant tumor and remained for 31 days, he would incur estimated charges of $2,375 for the cost of this spell of illness. The basic medicare plan as proposed, would pay $1,217 of this amount; $552 would be paid by the supplementary plan, leaving a remaining $606 to be paid by the individual. In the case of indigent and medically indigent persons receiving social security benefits this would constitute a severe financial burden, in no way covered by the program. If the above illness were extended to 3 or 4 months of general hospital care, payments would be beyond the means of the great majority since the insurance part of H.R. 6675 does not pay for any additional period of general hospital care beyond the 60-day provision.

There are several specifics that we would like to see changed or amended in this bill. (1) The Secretary of the Department of Health, Education, and Wel-

fare is the only individual mentioned having authority for the administration of this bill. However, it is left completely up to the Secretary as to which department he will designate for administration at the State level, and possibly at the Federal level for day-to-day administration of the provisions of this important bill. We would strongly recommend that the department of health in each State be specified as the department best qualified to administer said program in the various States. We would urge that such language be inserted into the bill, or if this cannot be done, that the bill be so amended as to allow the Governor of each State to designate that department which he believes best equipped to administer the bill in his own State.

(2) There is mention of "reasonable cost of services" in the bill. In that section pertaining to change in child health laws, the bill would not provide adequate funds for the payment of the "reasonable cost of services" as defined elsewhere to service crippled children. Unless the amounts of money appropriated are substantially increased, the result would be that decreased numbers of handicapped children could receive necessary medical and surgical treatment services because of increased payments required by the bill. Most States have negotiated contracts with participating hospitals at far less than the daily cost of services in that hospital for the care of handicapped children.

(3) There is also a section of this bill which denies payments for physicians' services in hospitals such as pathologists, X-ray specialists, and certain laboratory specialists. This is diametrically opposed to the usual practice of hospitals to employ physicians under negotiated contractual arrangement, to perform this type of specialized and essential work in hospitals. Certain of these costs should definitely be included in the cost of hospitalization. We feel that the individual patient would not be able to pay these additional costs as well as the deductibles already charged under the provisions of the bill.

(4) On page 125 of the bill, it is mentioned that by 1970 support of certain sectain sections pertaining to welfare programs will be completely supported by Federal and State funds. If it is intended to completely eliminate local payments for certain welfare services included under the umbrella of this legislation, I would recommend amendment to provide for local financial participation, giving the State ample authority to establish higher standards for the necessary welfare services to their own citizens.

Further, we believe that the voluntary supplementary insurance plan in general provides better comprehensive benefits than does the plan for medical care under the social security title. We would suggest that if all individuals in the United States are ultimately to be covered by some type of national medical care insurance, that this would be better accomplished through a mechanism similar to that providing voluntary insurance plan under H.R. 6675.

STATEMENT OF JOHN W. EDELMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, INC., WASHINGTON, D.C.

At the opening of this statement, the National Council of Senior Citizens wishes to thank the committee chairman, Senator Byrd, for his kindness in inviting former Congressman Aime J. Forand, the founder and president emeritus of our organization, to be the first public witness in support of this bill at these Senate Finance Committee hearings.

The distinguished former legislator from Rhode Island worked diligently during his years in Congress to enact a bill to provide health care of the aged through the social security system. And, when Aime Forand retired from Congress because of ill health, he organized the National Council of Senior Citizens on behalf of thousands of completely independent, widely scattered, older people's clubs across the Nation. He established a national voice for them.

Many of these older people's clubs, and councils of clubs, supported Aime Forand's early struggles on behalf of the Forand bill, and they now urge enactment of what has become popularly known as "medicare" but by which we have always meant the provision of hospital insurance for the elderly financed under social security. Your committee has heard from the Council of Golden Ring Clubs of New York which is one of our affiliated organizations. The National Council of Senior Citizens, in 4 years, has grown to represent more than 2,000 such clubs with a combined membership of over 2 million.

Under the leadership of Aime Forand, the National Council of Senior Citizens jumped into the vanguard of those national groups which have sought to shed

light—and not merely heat—on the desperate problem of providing health care for America's elderly with dignity—without forcing proud oldsters onto relief rolls. I am proud to have been elected president of the organization a year ago when Aime Forand was forced to retire from active work with us—again because of ill health.

Our club members in all States have helped the Members of this Congress come face to face with the bitter facts concerning the desperate needs of our older Americans and they have acted always on the principle that health needs of the aged affect the whole family and the entire community.

Many thousands of our club members have died since August 1961 when Aime Forand first raised the banner of this organization to fight for the kind of legislation which is included in the provisions of H.R. 6675 which is now before this committee. Many more will die before the bill—if it passes Congress as envisioned—will go into effect on July 1, 1966. They urge you to pass this bill to help America's future.

I know of no member of the National Council of Senior Citizens who was not thrilled by the action of the U.S. Senate in adding medicare provisions to the House-passed social security amendments which came up for consideration last year and which, regrettably, omitted this urgently needed program. Had agreement been reached in conference, this program could have started this summer.

However, we are tremendously encouraged by the far-reaching proposals for improvement of the health security of the elderly recently voted so overwhelmingly in the House. We know it represents a victory for all of America—not just the aged—for it will importantly benefit the economic security of the younger workers who were trying to meet the problems of their children's education while trying to assist their own aged parents to meet the spiraling costs of health care.

Before we ask your special concern for particular details of the comprehensive, far-reaching measure which is known as H.R. 6675, we wish to express our wholehearted support of the general provisions of the legislation and urge you to grant it immediate favorable consideration.

We are deeply gratified that its provisions for institutional care and related benefits accept the extension of the proven principle of contributory social insurance. In this respect America will now be able to catch up with what the industrial nations of Europe did for their elderly more than 50 years ago. Health care becomes a matter of earned right.

We also support the bill's provisions to help pay the costs of physicians' services and which use Federal funds to match premium contributions from the elderly. We are grateful that this program recognizes it is appropriate to use funds from general revenues to help pay the costs of health insurance without the application of a means test.

The cash benefit increases in social security recommended by this bill are desperately needed by millions of elderly—particularly by those more than 8 million aged whose only means of support comes from the social security system.

But the suggested increase is not enough. The recommended 7-percent raise hardly keeps pace with the rise in living costs since the last general increase in 1958, and we believe that the recommendations of the Advisory Council on Social Security for a 15-percent benefit increase would permit the elderly to share in the advancing standard of the American way of life—instead of dragging behind it.

Our affiliated groups in all States have been helpful in providing information which has helped us gage the effectiveness of the Kerr-Mills program of medical assistance to the aged—and at previous hearings of this committee and other committees of the Senate we have expressed our views concerning the inadequacies of this program.

But the health insurance programs of this bill will relieve the participating States from the major part of the heavy financial burden they are now carrying in their efforts to meet the health costs of the elderly on an assistance basis. We welcome the provisions of this bill which would combine additional Federal aid with the State funds thus freed, to provide a more adequate MAA health care program. However, we feel administrative responsibility for this program might be better in health departments rather than in welfare agencies.

However, this bill can stand some improvement in two particular areas in which we feel very qualified to speak.

Our first concern is for the removal of the deductible and coinsurance provisions. At the very time older people retire and experience drastical reductions in income they find themselves faced with health care expenditures much greater

than those confronting younger people. 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 go to hospital 2 or more times.

But the older people who enter hospitals are also the ones who will have large other medical expenses. In 1962, for example, medical care costs for all aged couples averaged about $442—but the medical expenses of those aged couples with one or both members hospitalized during the year averaged $1,220.

Why then, must we hit the aged who are hospitalized—and who are needing physicians' care the most—with these discriminatory deductible and coinsurance charges? In the section of the bill which is social security based there are deductibles of $40 for the first hospital day and $20 for diagnostic services. Then, under the voluntary coverage for physicians' services there are a $50 deductible and 20-percent coinsurance provisions. This penalizes the poorest of the aged—particularly those four out of five aged beneficiaries who have been found to be dependent on social security as their major source of income and the one out of two beneficiaries for whom it is the only income.

If a sick elderly patient was treated by his doctor, later given a diagnostic examination and finally removed to hospital, he would be asked to pay $110 in deductibles and then additional unknown sums to meet the 20 percent of the physicians' and other services under the voluntary program. This might be too heavy a burden.

The National Council of Senior Citizens is happy to note the American Hospital Association is on record before this committee as also being opposed to the deductibles as confusing to old persons and liable to deprive them of needed care.

It is also probable that for many of the sick poor the State assistance programs will need to pay these deductibles. A few days less hospitalization should meet the actuarial requirements of deductibles loss without serious effect.

The National Council of Senior Citizens also supports the American Hospital Association in its suggestion that provisions for outpatient diagnostic services be expanded to cover accidental injuries. Elderly persons are prone to falls and other accidents which require X-ray or other diagnostic tests.

Many of our elderly are paying an increasingly high proportion of their meager incomes to purchase needed drugs which have been prescribed by their doctors as essential for maintenance of their health standards. Some way must be found to provide Federal assistance for doctor's prescribed drugs for the aged—hopefully using generic or established names for the prescriptions instead of fabulously high priced brand names.

We do not believe that profitmaking home health agencies should be permitted to qualify for payment under the social security financed program for this would open the door to exploitation of the aged who are too willing to sacrifice service and quality for financial gain. For this reason we urge that the provision limiting payment to nonprofit agencies be restored.

Our final criticism of the social security health care section of the bill concerns the payment of services for the hospital specialists. Originally part of the King-Anderson bills S. 1 and H.R. 1, these fees have now been switched to the voluntary insurance sector covering physicians' services. This reduction in benefits from the original plan is a serious matter to older people. They would be forced to join the voluntary insurance program to get specialists' coverage at all—and then they would be asked to pay 20 percent of these costs after a $50 deductible.

We understand that American Hospital Association and others have criticized the specialists omission on many other grounds—principally that it would require disruption of medical care services that have developed over the years to a high degree of efficiency and quality of care in hospitals. It would also perpetuate and extend the piecework approach to assessing medical care costs—a decidedly inflationary procedure. Directing hospitals to change their systems is obviously direct Federal interference with customary hospital practice and should be avoided—as should the introduction of any new administrative procedure which would increase costs.

The National Council of Senior Citizens has had much experience working with older Americans—and we must express some concern for the magnitude of the task which faces the Social Security Administration in reaching the elderly with details of this great legislative measure when it wins congressional approval.

We wish to remind this committee that many of our older citizens are continually confused by Government communications—all communications of this

kind, no matter how well they are prepared. Moreover, this is an extremely complicated piece of legislation. Social Security Administration may have problems getting the elderly to sign and return their papers signifying they wish to authorize a deduction of $3 per month from their social security checks to pay their part of the premiums for the insurance plan for physicians' services.

It is our belief that much confusion could be prevented and much Federal Government time, labor, and money could be saved if at least the current social security beneficiaries could be automatically entered into the physicians payment plan, provided that they did not elect to drop out of the plan by March 31, 1966—the final date for acceptance.

Admittedly the Social Security Administration will still need to locate and contact the elderly who are not on social security rolls to make arrangements for their voluntary participation and set up billing procedures—but this is a much lesser task.

The bill is a legislative milestone—and its imperfections can be further remedied by approaches of reason and good will whenever the hierarchy of the American Medical Association will cease its senseless opposition.

We urge that the Senate Finance Committee speedily report this bill favorably with the improvements we have suggested to make it immediately one of the greatest social boons of the century.

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, SUBMITTED BY N. J. SWEARINGEN, DIRECTOR, WASHINGTON OFFICE

The American Public Health Association, representing the professional workers who provide leadership and day-to-day services in public health programs across the Nation, enthusiastically supports the enactment of H.R. 6675. Since 1958 our association has urged and supported attempts to provide for adequate health services to the aged and to other elements of our population with special health needs.

We congratulate this Congress on its responsiveness to a growing countrywide awareness of these national needs.

The competence, experience, and dedicated interest of our physician, dentist, nurse, scientist, and medical care administrator members in the welfare of our sick and disabled citizens qualifies us, we believe, to speak with authority regarding practical considerations in making this legislation work.

Volumes have been spoken and written over the past two decades on this problem. The paramount point, however, is that this must be a program good for people. Such assurance is not now contained in this bill. We have for years supported the concept of paid-up insurance to cover the health needs of the elderly. H.R. 6675 is intended to do this. Unfortunately, the motive and intent of the bill outshine the bill itself, which seems preoccupied with financing and quantity of services rather than with any assurance that the long neglected health needs of these groups will be met with high quality services.

It is a simple but annoying fact of life that the costs of health care almost defy budgeting. It is not difficult to plan for food, clothing and shelter, but it is impossible to foresee all eventualities in relation to illness and its medical costs.

This legislation or any other action taken by Government must in no way impede progress toward better medical care. We agree with the espoused principle that this bill should in no way supervise or control the practice of medicine or the manner in which medical services are provided. But every effort must be made to guard against creating a static situation or perpetuating and vastly extending unsatisfactory methods of providing care. Naturally, this legislation ought to allow room for innovation, for encouraging the improvement of medical care under our existing system of private medical practice. Additionally, full utilization of existing competencies and skills should not only be encouraged but guaranteed in order that the best of medicine be forthcoming.

Good quality health care is specific; it is tangible; it is obtainable—but it does not just happen. Although most persons can adequately judge for themselves the value of goods and services used in everyday living, the quality of health care is, by its nature and sophistication, vastly more difficult to evaluate even by professionals trained and skilled in the science and art. Safeguarding the quality of care to be given to the elderly, to the recipients of welfare medical care services, to children, to all of the millions who are to be covered under this bill is equally

important with assuring these persons care of some kind—be it good, bad, or indifferent. This can be achieved by due regard to a few practical assurances of sound administration of these benefits.

We propose three simple amendments to H.R. 6675 which are essential to improve the quality of services to be authorized by this legislation:

1. Part A of the bill should be amended so that the services provided by associated specialists—radiologists, anesthesiologists, pathologists, and physiatrists—be restored as was proposed in S. 1.

2. Part B should assure full-service benefits, guaranteeing no additional charge to patients for services rendered, and arrangements made so that other than fee-for-service plans would be eligible for inclusion.

3. The bill should be amended appropriately so that the skills and competencies of State and local health departments will be utilized to the maximum degree feasible. This will insure that the quality of health care provided can be continuously reviewed and improved, rather than resulting in the development of a vast, expensive parallel which would only duplicate an existing health structure in government.

With respect to recommendation No. 1, we believe it would be a long step backward and a clear disruption of an accepted manner of providing health care to require that the services of the hospital-associated specialists be excluded from the hospital insurance program. This bill should not determine the administrative relationships between hospitals and physicians. Sufficient latitude for continuation of relationships of proved effectiveness and imaginative new arrangements in relation to these and other specialties should be encouraged so that continued improvement be possible. We join Secretary Celebrezze, the American Hospital Association, the AFL–CIO, and others in urging a return to this sound concept.

With respect to recommendation No. 2, we strongly urge protection against an additional charge to patients for medical services. This practice, not unknown with existing insurance programs, would defeat the highest intent of the bill. In addition, it is essential to amend the present provisions under part B so that coverage for health services on other than a fee-for-service basis will be possible. The provision of the bill that payment be based on a receipted bill or on the basis of assignment would exclude group health plans operating on a capitation payment basis which have been responsible for many of the outstanding improvements in the quality of American medical service. Amendment of this provision so that such groups would be included would protect advances made in our systems of delivering medical care rather than set back the clock.

With respect to recommendation No. 3, it is essential, if there is to be quality control of the services authorized by this legislation, that these new health benefits be directed by agencies with appropriate health and medical experience. It is imperative to remember that, in the main, H.R. 6675 authorizes only payment for medical services. It should be axiomatic that medical services be administered by a medically competent agency. We recommend as strongly as we can that appropriate provision be made to mandate utilization of existing health agency skills. Provisions should also be added to the bill to assist State and local health departments to improve these competencies where they do not now exist in the necessary degree.

The successes of health agencies in controlling disease, improving health, and extending our life span are almost unparalleled in recent history of public service. These successful experiences, in both the preventive and administrative fields, should provide the base for these proposed expansions and related health services.

In addition to these three points of paramount importance, there are several other changes which would materially improve the bill.

We recommend inserting in H.R. 6675 that portion of the Kerr-Mills Act which directs the Secretary, HEW, to establish standards for medical services, and further that the Secretary specifically delegate to the Public Health Service and to the Children's Bureau responsibility to establish minimum Federal standards. Both have had long experience in setting high medical standards.

Section 1902(a)(5) should be amended so that the State agency which administers, or supervises the administration of, medical assistance shall be the State health agency; and the local health authority or other appropriate local agency currently administering maternal and child health services administer medical assistance in such subdivision. This authority should apply to professional medical activities; for equally cogent reasons, the responsibility for certifying eligibility should belong to the welfare agency.

Section 1864(a) should be amended so that the State health agency, where able and willing, be contracted with by the Secretary to (1) certify hospitals, extended care facilities, and home health agencies which meet the criteria established for such agencies; (2) provide consultative services to institutions or agencies to assist them to qualify as hospitals, extended care facilities, or home health agencies; (3) provide consultative services to institutions, agencies, or organizations to assist in the establishment of utilization review procedures which are required by section 1861(k); and (4) evaluate their effectiveness. These activities require professional training and experience and therefore should be delegated to the State health agency.

It is essential that standards be established and protected in all portions of the bill which relate to medical services, including parts A and B, the medical assistance portion, and the maternal and child health and crippled children's portions. There must be available to the Secretary authority to set and enforce standards applicable to personnel, institutions, and facilities, including laboratories. There should be provision for the audit of services given as well as the quality of institutional care. Adequate authority for the Secretary does not now exist, especially in part B, and only appropriate amendment, as indicated above, will safeguard and protect recipients.

There should also be provision enabling a State to set standards higher than the minimum called for in this legislation. This applies particularly to the accreditation of hospitals. As written, the bill's language means that the Joint Commission on Accreditation of Hospitals—a voluntary organization not subject to the control of the Secretary, HEW, to whom this responsibility is delegated—is in effect setting maximum standards for certification. We believe this language should be amended to encourage higher standards of quality care.

Services mandated under the medical assistance program should be carefully reviewed for their pertinency. The five services listed are not appropriate in all instances, and we recommend that some flexibility be allowed to make these more responsive, specifically to the needs of children.

We have reservations as to the necessity for the 3-day hospitalization requirement prior to care by a nursing home or home health agency. We recommend that the operation of this aspect of the program be watched carefully and then evaluated to see if change is indicated.

In the definition of a "carrier" (section 1842), there should be inserted provision which would allow the State health care agency, responsible for coordinating all State health programs, to be listed as one of those entities who could serve as the carrier.

It must be pointed out to the committee that the amendments proposed to the maternal and child health and crippled children's services include payment of "reasonable cost" for inpatient hospital care. We take no exception to this provision except to point out that unless the ceilings on annual appropriations are increased sufficiently, the effect of this change will be an increased unit cost for care per child and fewer children can be cared for than at present. In every instance where medical services are to be provided for children, the administration of these programs should be assigned to the Children's Bureau.

The APHA has one overpowering interest in testifying on this bill: To make certain that this legislation shall provide really good health and medical services to the millions of Americans newly aided by the legislation. This is no time to "freeze in" unsatisfactory patterns of medical care, such as the obsolete and discredited caliber of services frequently offered in the past to the indigent, to say nothing of extending them to new millions of deserving and expectant citizens who have sought so long for so little. Rather, it can only be consonant with the vision of a new Great Society that we offer to these respected and respectable elders and to the children who will determine tomorrow's national productivity, the best quality of health care which our science and technology new makes possible. We are sure that this committee and the Congress share our objective and we hope these suggestions will be helpful in attaining our mutual goal.

NEW YORK, N.Y., *May 10, 1965.*

Senator HARRY F. BYRD,
Chairman, Senate Committee on Finance,
U.S. Senate, Washington, D.C.:

The National Association for Mental Health, by reason of its primary concern for better care and treatment of the mentally ill, has examined the proposed

Social Security Amendments of 1965 contained in H.R. 6675 as passed by the House.

We note that this bill in providing for improved medical care for the elderly, continues to discriminate against the mentally ill, we feel that mental illness can and should be covered on much the same basis as physical illness, and we therefore urge that all discrimination against the mentally ill be eliminated from this measure.

We support the proposals for improved health care for low-income and preschool children through special project grants, as provided in the child health amendments; and the removal of limitations on Federal participation in public assistance to aged individuals in mental institutions, as provided in the public assistance amendments.

PHILIP E. RYAN,
Executive Director, National Association for Mental Health.

STATEMENT OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. Chairman and members of the committee, my name is Rudolph T. Danstedt, director of the Washington office of the National Association of Social Workers.

The association which I represent has 45,000 members employed in public and private health, welfare, and recreational organizations. A substantial number of these members are employed in health programs as psychiatric and medical social workers and in various phases of planning and administration of health agencies including purchasers of health care such as welfare departments and labor unions.

This statement is based upon policy positions in health, social insurance, and public welfare formulated at the biennial delegate assemblies of our association.

The history of our support for health care benefits financed through contributory social insurance dates back to at least the time of the comprehensive proposals made by Senators Murray and Wagner and Congressman Dingell. We welcome this opportunity to pay tribute to these great legisaltors who almost a generation ago recognized that the social need for a system of health insurance was of equal importance with the system of old-age and survivor's benefits. We pay tribute, also, to Congressman Aimee Forand for his pioneering efforts in this area and to Senator Clinton Anderson and Congressman Cecil King for their persistent efforts to protect older people against the costs of hospital care.

Our association enthusiastically supports H.R. 6675 now before you because it ingeniously and effectively develops a system of comprehensive health care for the aged going beyond the essentially institutional care provisions of the administration's original recommendations as presented in S. 1. We were concerned as were many groups that S. 1 with its focus on hospital care would prove to be too limited excluding as it did payment for physician's services.

The fact that H.R. 6675 passed the House of Representatives with a large margin indicates that we are now willing to accept as a matter of public policy that, only through Federal leadership and the instrumentality of the social insurance system complemented by payments from general revenues can we assure an adequate system of health care for the aged. We cannot leave the provision for such care up to the 50 States, deductibility features under the income tax or combinations of private insurance carriers.

Although we shall make several comments and observations with respect to various titles of the bill, these are presented as constructive criticism and do not qualify our support of this legislation.

TITLE I, HEALTH INSURANCE FOR THE AGED

A Basic hospital plan

Coverage of specialist services

We urge that the original provisions of S. 1 to include coverage for the services of pathologists, radiologists, physiatrists, and anesthesiologists under the basic inhospital service be restored to this part of title I of H.R. 6675. Such services are the normal expectation of most patients with respect to hospital care and to transfer them to another payment arrangement would not only prove disturbing to many elderly persons but also much more expensive to the older person

because of the deductible and copay features of the voluntary supplementary plan.

Elimination of deductibles

We suggest the elimination of the $40 deductible for inpatient care and the $20 deductible for outpatient diagnostic services. We are concerned that such deductibles may stand in the way of elderly persons with low-income seeking medical care and so interfere with early preventive care.

Medical social services

We commend the inclusion of medical social services in the hospital inpatient, extended care facilities and home health services programs. Such medical social services occupy a key role in planning for medical care and can contribute significantly to reduction of length of stay by balancing health planning within and without the hospital.

B. Voluntary supplementary plan

Elimination of deductibles

We urge, as we do with respect to the basic plan, the elimination of the $50 deductible.

Importance of group practice plans

Although we understand that the legislation permits the arrangement of negotiations with group practice plans which now provide prepaid medical care to several million enrollees, we believe it is important that the legislative intent of including such plans be made fully clear. Such plans provide significant demonstrations in consumer-physician approaches to obtaining a high level of medical care and must be encouraged and supported.

Inclusion of recipients of public assistance in plan

We endorse strongly the provision that States can purchase into the voluntary supplementary plan for their assistance recipients thus affording these recipients access to medical services under the same terms as the insurance protected older persons.

PROPOSED TITLE XIX OF SOCIAL SECURITY ACT—EXPANDED KERR-MILLS MEDICAL CARE PROGRAM

We support generally this proposal as an important and necessary method to make more adequate medical care available particularly to children in needy families.

We commend particularly the elimination of residence requirements, and the limiting of support responsibility to that of spouse or child under 21.

Extending eligibility to all medically indigent families with children

Since medical care will only be provided to children under the eligibility terms of the State law with respect to ADFC, we are concerned that thousands of medically indigent families and children will be denied medical assistance because of State limitations on eligibility for AFDC.

Since this is a medical care program, we believe that children in need of medical care should be provided such help even though such children are not eligible for financial assistance under the State's laws.

Assuring quality of medical care

This expanded Kerr-Mills program will suffer from the same unevenness of scope of benefits and adequacy of health services now so characteristic of Kerr-Mills in the over 45 States in which it is in effect.

It is important, therefore, that the legislation and its legislative history record the importance of providing a high quality of medical care to these particularly disadvantaged children. Assuring preventative and curative medical care to children in low income families is a basic investment and key element in the opportunities emphasis of the Economic Opportunity Act. The Department of Health, Education, and Welfare have authority in approving State plans to impose standards for medical care which States must meet.

CHILD HEALTH CARE PROGRAM AMENDMENTS

Endorsed is the bill's proposal to increase the authorizations for the programs of maternal and child health and crippled children's services under title V of the Social Security Act to $60 million by 1970.

Endorsed further are the authorizations for new programs for training of personnel to serve crippled children and to provide health care for needy children and to extend the authorization for mental retardation planning for another 2 years.

PUBLIC ASSISTANCE AMENDMENTS—INCREASE IN PAYMENTS

Inadequacy of AFDC payments—Need for an income floor

We support the proposals to increase the average monthly payments for the adult titles by $2.50 and for the AFDC title by $1.25. However, these increases, particularly for AFDC, will not correct the gross inequities among States in AFDC ranging from $9.50 to $48 per recipient per month. Our association holds that these inequities cannot be corrected until by Federal policy a minimum income floor for assistance affording decency and dignity is established.

OLD-AGE, SURVIVORS AND DISABILITY INSURANCE AMENDMENTS

Cash benefit increase supported but increase insufficient

The 7 percent increase in cash benefits with a minimum $4 monthly increase—the first increase in benefits since 1958—is badly needed. Even under this increase, however, the majority of elderly couples will draw substantially less than the poverty floor of $3,000 a year.

It has been estimated that to bring the average retired couple up to $250 a month, the increase in benefits would need to be 15 percent.

Substantial increase in tax base and governmental contribution required for more adequate payments

Our association believes that we are facing now the need for a substantial taxpayment to the OASI Trust Fund in order to provide more adequate retirement levels to the already retired without imposing a substantial increase in tax rates on the currently employe.. To provide a retirement level in the future reflecting the advancing standard of living, a tax base in the order of $13,000 would be needed. The recent report of the Advisory Council on Social Security indicated that such a tax base would be required if the proportion of taxable wages to wages earned was to be restored to somewhere near the situation in the early days of the social security program.

Extension of coverage for child and liberalization of eligibility for disability insurance

Proposals to provide survivors benefits to children until age 22 while in school and to permit entitlement to disability insurance at the end of 6 months of total disability are endorsed by our association.

Conclusion

Our association considers H.R. 6675—imaginative and highly significant legislation. For our older citizens it is a basic implement in the war against the condition of poverty in which too many old people find themselves.

The members of our association have urged the need for this legislation for many years. We are prepared in our various capacities to lend our efforts to the successful administration of the programs and benefits this bill proposes.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., May 7, 1965.

Hon. HARRY BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I respectfully request that the Senate Finance Committee give serious consideration to a bill introduced in the Senate by the Honorable Vance Hartke, which is identical to a House bill which I and many of my colleagues in the House introduced there to help America's senior citizens by amnding the Social Security Act to permit elderly widows and widowers to remarry without suffering the loss or dimunition of their social security benefits, as is the case at present.

The so-called medicare bill was reported by the House Ways and Means Committee and passed by the House without this proposed provision being incorporated, and I am hopeful that the Senate Finance Committee will see fit to incorporate it in the version of the medicare bill which you will send to the Senate floor.

Under present law, a widow or widower who remarries is no longer entitled to the benefits previously enjoyed as the surviving spouse of the deceased person covered by social security, and takes only such benefits as would derive from the new spouse.

This generally means a very substantial reduction in the social security payments of the widow or widower remarrying. Forcing the two spouses to live upon total pension benefits very substantially less than the spouses would have received individually without remarriage prevents them from enjoying companionship in their latter years, and/or forces them to share their lives with a companion out of wedlock.

Last year, 2,158,012 widows and widowers over age 62 drew social security benefits in the United States, but only 6,000 of these millions remarried. This was not because they'd lost interest or couldn't find a mate, but because of monetary considerations. The average income for widowed persons was $67.85 a month, or $2.26 a day, according to social security records. When a widow remarries, she loses between $20 and $30 a month on an average. That means her $2.26 a day is cut nearly in half.

From what's left, she must help her new husband, also on pension, pay for rent, food, medicine, transportation, utility bills, and clothing, to say nothing of insurance, hospital bills, and such luxuries as a movie or other entertainment.

There is no significant help in the new antipoverty legislation for poor people if they are old. But a recently issued social security bulletin noted that "every second person living alone and classified as poor in the United States is aged 65 or over."

With an ever-increasing influx of retired senior citizens making their permanent homes in New Jersey's Second District, which I have the honor to represent, I feel passage of the legislation I am supporting here will be of high importance to the individuals involved and to the economy of my district. Therefore, I respectfully request that every consideration be given this proposed legislation.

Thanking you, I am,

Sincerely yours,

THOMAS C. MCGRATH, JR.

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, D.C., May 4, 1965.

HON. HARRY BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Section 308 of H.R. 6675 relates to wives' and widows' benefits for divorced women. Under the language of the bill as it passed the House, a divorced woman must meet one of the following three qualifications, in addition to others, if she is to receive wife's or widow's benefits:

1. She was receiving one-half of her support from her former husband, or
2. She was receiving substantial contributions from him pursuant to a written agreement, or
3. A court order for substantial contributions was in effect.

Under Texas law there is no provision for permanent alimony (article 4637 Vernon's Texas Stat.). There is a provision for the support of children until they reach the age of 18 (article 4639a, Vernon's Supp.). Further, the court may make a division of the existing property in such a way as seems to it just and right, having due regard to the rights of each party and the children (article 4639a, Vernon's Supp.), but there is no authorization under Texas law for continuing support to a divorced wife by her former husband.

Members of my staff have discussed this situation with Evelyn Keenan of the Social Security Administration, and she has advised them that legal experts of the Social Security Administration do not believe that the present language of H.R. 6675 would cover the typical case in Texas, which would be a division of the estate, rather than some form of continuing payment.

It is an unusual man who would make continuing payments to his former wife when he is not compelled to do so by law. Therefore, cases which would satisfy

the present criteria of H.R. 6675 would be almost nonexistent in Texas and in any other States not having alimony provisions.

I feel that it would be most unjust to say to women who have come under the effect of a perhaps unwise State law, "Because you have been denied adequate support by State law, you must also be denied adequate support in your retirement years by the Federal law."

With the intention of affording substantially equal treatment in all States, I suggest the following additional language on page 205, line 14; page 209, line 10; and page 213, line 15, of H.R. 6675:

After "individual," change dash to comma and insert:

"or, in States in which continuing support is not available under law, there was in effect a court order dividing property or other action equivalent to a finding of an obligation of continuing support, as determined under regulations prescribed by the Secretary to assure uniformity of treatment of individuals within the several States."

I am not wedded to this particular wording. The intent of the language is what most concerns me, viz, that coverage not be unintentionally subverted by an unfortunate feature of a particular State law, but that coverage be substantially equal in all States.

With kindest personal regards.

Sincerely yours,

RALPH W. YARBOROUGH.

THE COURT OF COMMON PLEAS,
COUNTY OF DEFIANCE,
Defiance, Ohio, May 7, 1965.

Hon. HIRAM L. FONG,
U.S. Senate,
Washington, D.C.

DEAR SENATOR FONG: In the April 30 issue of the Congressional Record I observed where you introduced two amendments to H.R. 6675, Social Security Act Amendments of 1965, on which the Senate Finance Committee has just begun hearings.

I wish to submit a situation where I feel your amendments would be most helpful. My nephew, Ronnie Batt, of Defiance, Ohio, is 21 years of age, married, and has one son. To date he has had four open-heart surgeries at St. Vincent's Charity Hospital, Cleveland, Ohio. He is scheduled to return on May 12, of this year, for a fifth open-heart surgery. In view of the great cost involved it is questionable whether he knows of the total amount of his indebtedness at this time. It is not at all improbable that his condition was aggravated by his attempts to return to work. At his age he cannot meet the requirements for social security benefits because of his limited period of employment.

I want to express my appreciation of your efforts and only hope that you will be successful in having your amendment adopted.

Very truly yours,

DAN BATT, *Judge.*

SMITH KLINE & FRENCH LABORATORIES,
Philadelphia, Pa., May 18, 1965.

Hon. HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: As a manufacturer of prescription drug products, we are concerned about the drug provisions in H.R. 6675 as passed by the House. We believe that the language used to define drugs in subsection 1861(t) is too narrow and will unwisely restrict the physician in his choice of medicines.

H.R. 6675 provides that payment for drugs and biologicals administered to medicare beneficiaries is to be limited to:

A. Drugs and biologicals listed in four publications; namely, in the "United States Pharmacopeia," "National Formulary," the American Medical Association's "New Drugs," and in "Accepted Dental Remedies."

B. Drugs and biologicals that are approved by the pharmacy and drug therapeutics committee of a hospital.

Consequently, the proposed legislation will create two categories of drugs: one for which payment will be authorized and one for which payment will not be authorized. The result will be to deny to many patients many new and effective medicines that have been or will be approved by the Food and Drug Administration.

The reasons why the present language in subsection 1861(t) is too restrictive are as follows:

A. With respect to the listed publications:

1. Aside from other important omissions, nearly all combination drugs (those containing two or more active ingredients) will be excluded, because they are not listed in the four publications named in the bill. On this basis, 35 of the 100 most frequently prescribed products in use in the United States today will be excluded. One example is our own product Combid, which is widely prescribed for ulcer and other gastrointestinal disorders. The fact that about 2 million prescriptions were filled for this product in 1964 gives some indication of its general acceptance and wide use by physicians. Combid is a combination of prochlorperazine and isopropamide; and although it would be possible theoretically for a doctor to prescribe the ingredients of Combid in two separate prescriptions, it would be impractical and expensive to do so.

2. There is often a delay of as much as 2 to 3 years before a new drug is listed in the standard references cited in H.R. 6675. For example, our product Compazine, used extensively in treating the mentally and emotionally ill, was introduced in 1956. But this drug was not listed in any of the references until 1960.

3. In some cases, these references do not list all of the dosage forms in which a widely useful drug may be available. For example, our product Dexedrine is available in several dosage forms, but the most widely prescribed form (Spansule capsules) is not listed in the aforementioned references.

It is a common misconception that the "United States Pharmacopeia" and "National Formulary" are lists of drugs endorsed for their therapeutic value. This is not the case. Rather, they are important and necessary legal reference standards of purity, identity, and strength for many useful drugs and for many ingredients that are used in preparing medicines.

For example, "National Formulary XII" states: "The inclusion of a drug in the "National Formulary" is not intended as an endorsement of its therapeutic value."

Likewise, "New and Non-Official Drugs for 1964" (the most recent edition) states: "Drugs which the (AMA) council and its consultants consider to be of questionable or of unproved value are included along with drugs that are considered useful. Mere inclusion therefore does not constitute council endorsement of the efficacy of a drug."

B. With respect to therapeutics committees of hospitals:

1. It is true that subsection 1861(t) permits a drug to be used if it is approved by the pharmacy and drug therapeutics committee of a hospital, even though the drug is not listed in the references. It is estimated, however, that considerably more than half of all hospitals do not have such committees; and, even where such committees do exist, there is a lack of uniformity in their functions and responsibilities. Therefore, two undesirable possibilities may occur:

(*a*) Certain drugs may be considered acceptable and may be given to medicare beneficiaries in some hospitals but not in other hospitals; and

(*b*) A patient might receive a drug while hospitalized, but payment might not be made for the same drug after entering an extended-care facility.

We believe that the drug provisions in this legislation will set important precedents. In our judgment, it is essential that the wording of the drug provisions be such as to eliminate the restrictions outlined above. We respectfully recommend that the Senate Finance Committee consider adoption of a revised wording substantially to the following:

"The term 'drug' and the term 'biologicals' include only such drugs and biologicals as are ordered or prescribed by attending physicians for the care and treatment of patients and which may lawfully be introduced into interstate commerce under the Federal Food, Drug, and Cosmetic Act."

This definition would permit physicians to prescribe the drugs or biologicals necessary for the treatment of their patients, and at the same time would afford the protection of the Food, Drug, and Cosmetic Act against dangerous or worthless medication.

Very sincerely,

WALTER A. MUNNS, *President.*

COMMUNITY SERVICE SOCIETY,
New York, N.Y., May 14, 1965.

STATEMENT SUBMITTED BY THE COMMITTEE ON AGING WITH THE CONCURRENCE OF THE COMMITTEE ON FAMILY AND CHILD WELFARE

The Committee on Aging with the concurrence of the Committee on Family and Child Welfare in the Department of Public Affairs of the Community Service Society of New York, submits this statement in support of the intent of H.R. 6675, the Social Security Amendments of 1965. Early and favorable action is urged to extend the benefits and coverage of the social insurance program, to liberalize the public assistance program, and to strengthen the preventive public health program. The bill represents a significant and positive attack on poverty through direct provisions to ameliorate its current impact on families and individuals and to stem its resurgence in the future.

The Community Service Society, founded in 1848, is the oldest and largest voluntary family welfare agency in the country. Its primary objective is to preserve and strengthen family and community life. It has always combined programs of social action and research with its direct services to troubled families and individuals.

The society has a long record of citizen concern about adverse community conditions and of citizen action to improve social conditions after judicious weighing of facts and expert opinion. In reviewing H.R. 6675 we considered its provisions in the light of our prior position statements, notably one on the Public Welfare Amendments of 1962 and another on a Federal health care insurance program for the aged under social security. And we considered its likely results in lessening the destructive impact of inadequate income and illness on the most vulnerable segments of the population; that is, the old and the young, and on their families who turn to us for help in the resolution of overwhelming personal problems.

We reiterate our support of the intent of H.R. 6675 and we endorse its major provisions as constructive steps to strengthen family life. We offer comments on the several titles of the bill and we venture to suggest modifications, limiting these to basic questions in the expectation that cumulative experience and economic and social changes will dictate the direction of future amendments. We pause here to note that Congress has been sensitive to the need for changes in the 30 years since the enactment of the original Social Security Act. We believe this will continue to hold true for a future that no one can foresee or foretell fully.

Title I

First, we strongly support the basic insurance program of hospital and related benefits for the aged. It meets criteria that we deem essential in that it (*a*) is financed by payroll taxes levied under the existing social security system; (*b*) is available as a right and without a means test to all persons 65 years and older who are entitled to old-age and survivors insurance or railroad retirement benefits; (*c*) is to be administered uniformly throughout the Nation in respect to eligibility requirements and the levying of payroll taxes; (*d*) provides uniform benefits with unit pricing set on a reasonable cost basis; and (*e*) appears to include adequate legislative safeguards to prevent excessive or undue use.

The transitional and time-limited provision for "blanketing-in" uninsured individuals is understandable, appealing and not without precedent. Use of general revenues to cover the benefits to this group preserves the fiscal soundness of the program. We do not count this humane deviation (which the passage of time eliminates) to violate significantly the concept of a self-supporting contributory system.

In one respect this bill has a puzzling, disturbing but correctible flaw in its definition of hospital inpatient service. We refer specifically to its exclusion of the services of radiologists, pathologists, anesthesiologists, and physiatrists. Patients are accustomed to the inclusion of the services of such specialists in the basic hospital charge for inpatient care. Hospitals would be forced to revise established administrative arrangements for elderly patients but not for others, and widely accepted principles and accounting methods long used by hospitals and prepayment agencies to compute costs for all patients would be set aside. For the sake of the older person who has come to expect comprehensive and

economical health care as a result of this legislation and for the sake of preserving all that is sound and progressive in hospital care, the services of the radiologist, pathologist, anesthesiologist, and physiatrist should be restored to H.R. 6675 as covered hospital inpatient services. Failure to do so would leave a serious gap in coverage, and thus partially defeat the purpose of the bill, as well as create severe administrative disturbance. Since the services in question account for only 4 percent of hospital costs, and thus an even smaller proportion of the costs of the totality of the programs which would be provided by this basic prepaid insurance program, this important correction could readily be effected.

Second, so long as the prepaid program is limited to hospital and related care, we recognize the need for and favor establishment of a voluntary supplemental insurance program covering physicians' and surgeons' fees, as well as other related and supplemental items. We would much prefer, however, that this voluntary plan be established on a fully self-sustaining basis rather than depending, as it does in the bill, on contributions from the U.S. Treasury for 50 percent of the cost.

Since both programs require close review of experience with respect to such matters as utilization, reasonable costs and reasonable charges, the effect of deductibles, quality and comprehensiveness of care and services, and overall administration, we indorse the provisions of the bill establishing the Health Insurance Benefits Advisory Council and the National Medical Review Committee.

Third, we support the establishment of a single and separate medical program under a new title (XIX) to the Social Security Act. This (*a*) replaces the differing provisions now scattered in five titles of the act for the financially needy, and (*b*) offers States the option to extend an expanded medical assistance program to the medically indigent. We support the increase in Federal reimbursement for this program and the requirement that States must continue their present level of expenditures in order to receive any additional Federal funds as a result of expenditures under the new program.

We welcome the series of requirements that must be incorporated in any State plan in order to qualify for this new program which would combine Federal aid with freed State moneys to provide preventive health services as well as treatment services of high quality for all those persons—aged, blind, and disabled adults and dependent children—for whom no other, or inadequate provisions now exist. These requirements will eliminate many differences and inequities in the various State programs. We believe, however, that the requirements where appropriate (as in respect to the responsibility of relatives for support of needy kin and in the prohibition against imposing residence and citizen requirements) should be identical for all State plans for all categories of public assistance, since differences are cumbersome and confusing.

TITLE II

We unequivocally support the extension of programs for maternal and child health services, for crippled children services, and to combat mental retardation. And we welcome the addition of school and preschool health programs for children in low-income families. We view these as investments that will pay dividends of great value in the years to come.

TITLE III

We endorse the widened coverage, the increased cash benefits and the liberalization of the retirement test and other aspects of the old age, survivors and disability program of the Social Security Act under a financing plan that assures the continuing fiscal soundness of these trust funds.

TITLE IV

We generally support the public assistance amendments, although we deplore the widened disparity between Federal reimbursement for the adult categories as against the category for aid to families with dependent children. Here we note that Federal grants to States for a broadened medical assistance program afford an opportunity for States to improve their AFDC programs.

IN SUM

The Committee on Aging, with the concurrence of the Committee on Family and Child Welfare, views H.R. 6675 as a tremendous advance in social policy and social administration affecting the lives of millions of Americans. Recommendations we have noted for your consideration as amendments in your review of the provisions of the bill. We urge early and favorable action on vital amendments to the Social Security Act that will bring closer to realization our hopes for an America in which all Americans have an opportunity to grow up with hope for a satisfying and independent future and to earn through their own efforts and contributions (and those of their employers) financial security for their old age.

INTER-INDUSTRY WORKMEN'S COMPENSATION STUDY COMMITTEE,

Honolulu, Hawaii, May 10, 1965.

Hon. HIRAM L. FONG,
U.S. Senate,
New Senate Building,
Washington, D.C.

DEAR SENATOR FONG: I am writing on behalf of the Inter-Industry Workmen's Compensation Study Committee which is comprised of members from the construction, sugar, pineapple, public utility, trucking, restaurant, insurance, and dairy industries. The 410-member Hawaii Employers Council is also represented on the committee.

Our committee met on May 4, 1965, to discuss the effects of the disability benefit provision of the Social Security-Medicare bill (sec. 303 of H.R. 6675), and wish to express our concern regarding the adverse effect on State workmen's compensation programs which would result from the passage of this measure.

Under present law, the social security disability program is intended to cover cases of severe, long-term disability. "Disability" is 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 to be of long-continued and indefinite duration. Section 303 would drop the latter requirements. It would make benefits available to covered workers who have been out of work for 6 months with a medically determinable mental or physical impairment. The effect of section 303 would be to throw open the social security disability rolls to thousands of workers with temporary, short-term disabilities—even though they were already collecting under State, local, or employer-financed disability benefit plans including workmen's compensation.

It is difficult to assess the magnitude of liability against the social security program which would result from passage of this measure. We can assume, however, that there will be a vastly increased administrative burden due to the large number of persons with temporary short-term disabilities who will go on the rolls. Every one of these persons would have to be contacted on a month-to-month basis to establish their continuing eligibility.

Rehabilitation is a very important function in workmen's compensation cases, particularly in those involving total disability. It is reasonable to predict that those disabled workers receiving tax-free, duplicated benefits, perhaps totaling more than their normal take-home pay would have little incentive to accept the risk, pain, and struggle involved in trying to become self-supporting again. We fear that section 303 will indeed have the effect of increasing the number of persons who remain totally disabled indefinitely.

The current concept of workmen's compensation which has developed over the past 50 years is based on the premise that work injury programs can best be administered at the State level. Further extending the influence of the Federal Social Security Act into the field of State workmen's compensation would probably tend to weaken the State systems.

We understand that hearings on H.R. 6675 are being held by the Senate Finance Committee. We are hopeful that you can support our views on this subject and respectfully request that you convey our opposition to section 303 to all members of the Finance Committee.

Very truly yours,

Dorothy Rish,
Miss DOROTHY RISH,
Chairman.

STATEMENT OF HON. CLAIR A. CALLAN, A REPUBLICAN IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. Chairman, it was God who instituted matrimony and decreed that: "Yo shall live together until death do you part." Man in his wisdom has loosened these bonds to some degree.

These changes, plus the millions of our senior citizens now on social security find that they have in many cases created social problems. For example, the average widow receives $67.85 a month—$80 a month is the maximum amount. Now, if she marries a widower who is also on social security, this "act of marriage" will decrease their total meager social security benefits—some $20 to $30 a month.

I support H.R. 2465 in order to allow these folks to live in God's blessed state, if they so desire, with the peace of mind, and allow them to keep their joint social security benefits at the same rate they are now receiving separately.

Thank you Mr. Chairman.

NATIONAL TAXPAYERS CONFERENCE,
Boise, Idaho, May 14, 1965.

HON. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: In January 1964, 24 of the statewide citizen-taxpayer research organizations comprising the National Taxpayers Conference concurred in a statement presented before the House Ways and Means Committee on the legislation then under consideration to provide a compulsory hospital insurance program for the aged under the social security system. The major focus of that testimony was upon the increasing burden of the social security tax.

That legislation, of course, was not enacted by the 88th Congress. However, the measure (H.R. 6675) which the House passed on April 8, 1965, and which is now under consideration by the Senate Finance Committee, is much broader in scope and appears certain to result in even heavier burdens upon the taxpayers.

Therefore, as executive manager of Associated Taxpayers of Idaho and current chairman of the National Taxpayers Conference, I am taking this means, on behalf of the State organizations listed on the attached sheet, to present certain comments as to the financing provisions and the fiscal impact of the pending legislation. While it is understood that there would be no opportunity for an appearance before the Senate Finance Committee, perhaps this statement can be included in the printed record of the hearings.

Examination of the report of the House Ways and Means Committee on H.R. 6675—the Social Security Amendments of 1965—raises certain serious questions as to the extent to which the taxpayers of this Nation may really be aware of the new burdens which this legislation will impose, not only in the form of increased payroll taxes, but also upon the general fund of the Treasury, financed through general revenues.

The fact that the compulsory hospital insurance program will be financed by a technically separate payroll tax to be paid into a separate hospital insurance fund is really of little consequence, from the standpoint of the total burden upon the taxpayer. The tables which are found at the conclusion of the House committee's report are quite revealing.

Beginning January 1, 1966, the combined tax rate on employer and employee under the old-age, survivors, disability, and hospital insurance programs will total 8.7 percent, an increase of 0.45 percent over the rate scheduled under existing law, and 1.45 percent higher than the actual current rate. By 1970 this combined rate will reach 9.8 percent and by 1980 it will total a startling 11 percent—assuming no subsequent revisions by the Congress.

These increases, in the tax rates, combined with increases in the taxable wage base—to $5,600 on January 1, 1966, and to $6,600 in 1971—will result in substantial increases in the social security tax burden. For employees with wages equal to or in excess of the taxable wage base under H.R. 6675, the combined employer-employee tax of $487.20 in 1966 represents an increase of $139.20 over the tax paid this year, and of $91.20 over the tax which would have been paid in 1966 under present law. By 1971, the combined employer-employee tax will total $646.80—or $202.80 more than would be paid in that year under the tax rates and wage base established by presently existing law.

When one recalls that the combined tax rate when our social security system was first established was 2 percent, applicable to a taxable wage base of $3,000, there is certainly ample justification for the warning that the social security tax is becoming an increasingly burdensome tax for a growing number of persons.

Considering the effects of these tax increases in a different way, payroll tax collections for existing social security programs in 1965 will total an estimated $17.2 billion. In 1966, including the tax increases provided in H.R. 6675, these collections will increase by $4.7 billion, to $21.0 billion; and by 1970 they will total more than $31.6 billion—an increase in collections of more than 80 percent over the next 5 years.

If there were any doubts about the seriousness of this burden, they should be dispelled by the concern which has been publicly expressed by some economists recently—even before the enactment of this legislation—that the payroll tax increases might have a "depressive impact" on our economy next year. There have even been suggestions, it is understood, that the proposed increases in social security taxes to finance the costs of the new hospital insurance program and the liberalized OASDI benefits be put into effect more gradually, or "postponed" until the medicare payments actually begin. If such concerns are justified, it appears that we may be caught on the horns of a real dilemma—the choice between a soundly financed social security-medicare program and the possible economic deterrent effect of these tax increases.

One more point as to the proposed payroll tax increase schedule: with considerable interest and some curiosity, note has been taken of the recent testimony before your committee of the Secretary of Health, Education, and Welfare. With respect to the financing provisions of H.R. 6675, he suggested that the hospital insurance program was so "conservatively" financed that no further adjustment in the scheduled $6,600 taxable wage base would have to be made after 1971, and that if the wage base were to be increased after that time, there could be a downward adjustment in the hospital insurance tax rate.

Such an optimistic view appears to overlook certain factors. In the first place, the record shows that in the present OASDI programs there have been a number of increases in the tax rate, and also the taxable wage base, required over the years. Even more important, perhaps, the Secretary's assumptions completely overlook the temptations which confront the Congress—and which have not been resisted too successfully—to enact periodically liberalizations in both benefits and coverage, which, of course, increase the costs of these programs and could affect the financing requirements.

In our examination of the House committee report, we also have been struck by the relatively little attention which has been given in press and other reports to the very significant increases in expenditures against general revenues which will be required by other provisions of this legislation. So much attention and emotion has been generated by the so-called medicare program that these increases in general fund expenditures are in danger of being largely overlooked.

These added expenditures from general revenues, on a full-year basis, are estimated as follows:

1. Cost of hospitalization and related benefits for the aged who are not "insured" under social security—$275 million;

2. Federal Government matching contributions under the voluntary supplemental health care program, assuming 80 percent of the eligible aged enrolled—up to $560 million;

3. Increased Federal grants under the expanded Kerr-Mills medical assistance program—$200 million; and

4. Other increases in public assistance grants and related items—$290 million.

Thus, on a full-year basis, perhaps by fiscal 1967—and over and above the substantial increases in the payroll tax burden—Federal expenditures from the general fund of the Treasury could be increased under the House-approved legislation by more than $1.3 billion.

It is not reasonable, we suggest, to assume that even this imposing sum will represent the total budgetary impact of this legislation. Even without this new hospital and health care program, the Federal Government has considered it necessary for a number of years to provide special grants for construction, modernization, and expansion of hospitals and related facilities, and has provided financial assistance designed to assist in the training of more doctors, nurses, and technicians, for community health programs, and other health-related activities. The Federal budget for fiscal 1966 projects administrative budget ex-

penditures for health services and research in the next fiscal year at more than $2 billion.

Surely it is reasonable to assume that the broad new health care programs encompassed by H.R. 6675 will further tax the capacities of our hospitals, nursing homes, and similar facilities. Is it, therefore, unreasonable to assume that these will almost certainly result in eventual pressures for greatly increased Federal assistance to build more of these facilities? We think not.

In short, this legislation will substantially increase already burdensome payroll taxes, and add significant additional Federal spending from general revenues which will further accelerate the upward trend of Federal expenditures. It could conceivably open a Pandora's box of new spending demands which would further postpone the prospects of a balanced Federal budget.

It deserves a long and careful look by the Senate Finance Committee, by the Senate, and especially by citizens, so that the full implications of the tax and spending impact of this extremely broad and costly legislation may at least be fully understood by those who will have to bear these costs.

Respectfully submitted.

MAX YOST, *Chairman.*

P.S.—The above statement is concurred in by the following State taxpayer research organizations:

John H. McClure, managing director, Arizona Tax Research Association.
E. W. Sandberg, executive director, Colorado Public Expenditure Council.
Hubert W. Stone, executive director and secretary, Connecticut Public Expenditure Council, Inc.
Fred W. Bennion, director, Tax Foundation of Hawaii.
Max Yost, executive manager, Associated Taxpayers of Idaho.
Maurice W. Scott, vice president and executive secretary, Taxpayers' Federation of Illinois.
Raymond E. Edwards, executive vice president, Iowa Taxpayers Association.
Charles P. Stone, executive director, Minnesota Taxpayers Association.
Edward Staples, executive director, Missouri Public Expenditure Survey.
S. Keith Anderson, executive vice president, Montana Taxpayers Association.
Ernest L. Newton, executive secretary, Nevada Taxpayers Association.
Albert K. Nohl, director, the Taxpayer's Association of New Mexico.
Walter O. Howe, executive vice president, Citizens Public Expenditure Survey, Inc., of New York.
Morris Tschider, legal counsel, North Dakota Taxpayers Association, Inc.
David H. Sutton, executive director, Ohio Public Expenditure Council.
Steve Stahl, executive vice president, Oklahoma Public Expenditures Council.
George J. Annala, manager, Oregon Tax Research.
Henry W. Stevenson, Jr., executive director, Rhode Island Public Expenditure Council.
C. Irvin Krumm, executive manager and treasurer, Greater South Dakota Association.
Donald W. Jackson, executive secretary, Tennessee Taxpayers Association, Inc.
Alvin A. Burger, executive director, Texas Research League.
M. H. Harris, executive secretary, Utah Taxpayers Association.
John H. Current, executive director, Washington State Research Council.
Keith Osborn, executive director, Wyoming Taxpayers Association.
S. J. Arnold, executive director, California Taxpayers Association.
Lloyd Griffin, executive vice president and secretary, North Carolina Citizens Association, Inc.
Clarence J. Ziegler, executive director, New Jersey Taxpayers' Association, Inc.
Frank J. Zeo, executive director, Massachusetts Federation of Taxpayers' Association, Inc.
Forest A. Johnson, executive director, Nebraska Tax Research Council, Inc.

STATEMENT OF SENATOR HARRISON A. WILLIAMS, JR., ON H.R. 6675

Mr. Chairman, members of the committee, I wish to call to your attention what I believe to be a serious inadequacy in the bill H.R. 6675, Social Security Amendments of 1965, as passed by the House of Representatives. I refer, Mr. Chairman, to the intent of the Congress with respect to the freedom beneficiaries of this legislation will have to select for vision services either a physician skilled

in the diseases of the eye or an optometrist whenever such services may be authorized within the provisions of the Social Security Act.

I understand that it was the intent of the House Ways and Means Committee to provide the freedom necessary for an individual to choose the vision discipline he wishes to serve his needs.

There are, for example, a number of provisions which make this intent clear. In the public assistance amendments, under the definition of services, section 1905, page 142 of the bill, the term "medical assistance" means payment of part or all of the cost of "* * * eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select * * *."

Moreover, section 1902, State plans for medical assistance, required in subsection (12), pages 128–129, that a State "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 * * *."

Unfortunately, the House Ways and Means Committee did not find it possible to make clear the public's choice between a physician or an optometrist in all sections of the bill where it is needed.

Under the basic and supplementary plans, services provided by physicians to patients for eye examinations ending in referral for surgical or pathological treatment of the eye, contact lenses, the prescription and fitting of artificial eyes, and orthoptics or visual training, are reimbursable. No provision, however, is made for reimbursement when these services are provided by an optometrist.

The public assistance amendments provide that eyeglasses are to be made available when prescribed by either a physician skilled in the diseases of the eye or by an optometrist. Nevertheless, the question of an optometrist's services is left in doubt. Services provided by physicians, dentists, and nurses, on the other hand, are clearly spelled out in the definitions for this section.

Limitations such as these would seem to conflict with section 1802 on page 9 of the bill, which provides free choice by the patient guaranteed.

I would, therefore, urge that this committee consider the advisability of an amendment added as a new paragraph to section 1802, or as a new section 409 on page 296 of the bill. Such an amendment might appropriately read:

"Notwithstanding any other provisions of the Social Security Act, whenever payment is authorized for services which an optometrist is licensed to perform, the beneficiary shall have the freedom to obtain such services from either a physician skilled in the diseases of the eye or an optometrist, whichever he may select."

Mr. Chairman, I would also like to call the committee's attention to another deficiency with respect to optometry which arises under section 532 pertaining to special project grants for health of school and preschool children.

The report of the House Ways and Means Committee notes on page 80 that "About 10,200,000 schoolchildren are in need of eye care." Those provisions of the bill itself, however, which are designed to help meet these needs, would make Federal grants to schools of medicine with appropriate participation by schools of dentistry. Provisions are not included for such grants to schools and colleges of optometry, even though they, too, are eminently well qualified to assist in this important effort. There is, in my estimation, therefore, a very real need to amend the bill to make schools of optometry eligible for these special health projects grants.

Mr. Chairman, it is my hope that your committee will amend this bill to authorize funds for optometric schools and colleges and to protect the freedom of a beneficiary to choose an optometrist whenever vision services are made available to him. These amendments are of the utmost importance in making this legislation apply equitably and to meet adequately the vision problems of all our citizens.

STATEMENT BY SENATOR RALPH YARBOROUGH PROPOSING AN AMENDMENT TO H.R. 6675 ALLOWING BASIC HOSPITALIZATION INSURANCE FOR FORMER FEDERAL EMPLOYEES NOT COVERED BY HEALTH INSURANCE

Mr. Chairman, I wish to call to the committee's attention a most undesirable provision in H.R. 6675, the hospital insurance bill now before this committee.

Section 103(b) of the medicare bill states the following limitation of coverage:

(b) The provisions of this title shall not apply to any individual who—

(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.

This provision prohibits any Federal employee or former Federal employee from receiving the basic hospitalization benefits of the medicare bill if that person is now covered or, if he is retired, could have been covered by the Federal Employees Health Benefits Act. Mr. Chairman, the committee must not overlook the significance of this exclusion. It discriminates against a group of older citizens who need protection most.

It excludes any retired Federal employee who retired after July 1, 1960, and was not at the time of his retirement a member of some health benefits plan under the Federal Employees Health Benefits Act of 1959. It also excludes his wife, because under the language of this provision, she was at one time eligible to be enrolled in a health benefits plan, "had he or some other individual availed himself of opportunities to enroll in a health benefits plan * * *." In this instance, the failure of an elderly woman's husband to enroll in a Federal employees' health benefits plan now precludes the innocent wife from the protection of the medicare program.

Mr. Chairman, I have had the pleasure of service on the Post Office and Civil Service Committee since I came to the Senate. I was a member of the committee when the Health Benefits Act was written and enacted. That law originally required that in order to be eligible to carry one's health insurance into his retirement, an employee must have been enrolled in a plan for either the 5 years preceding his retirement or for the entire period from the first enrollment period until his retirement—whichever period was shorter. If the employee did not enroll during that first enrollment period—June 1 until June 30, 1960, and retired thereafter without completing 5 years under a health insurance plan, he had no coverage during his retirement years—the years he needs it most. Congress recognized the unreasonable restrictions of that requirement. In 1963, the Civil Service Commission came to the committee and suggested Congress liberalize these requirements. My distinguished colleague from West Virginia, Senator Randolph, presided over those hearings. The Chairman of the U.S. Civil Service Commission, the Honorable John W. Macy, Jr., told the committee:

"Despite every effort to inform them, many employees did not grasp the importance of enrolling at the first opportunity and those of this group coming up for retirement in the next few years will find themselves ineligible for continued coverage as retirees because of failure to enroll at their first opportunity."

After those hearings, Congress enacted Public Law 88-284, to liberalize the Health Benefits Act and extend health insurance coverage to those employees who were enrolled in a plan at the time of their retirement, regardless of the length of time they had been enrolled, whether or not they had joined at their first opportunity. But this still left out a small group of retired employees, and their wives, who had failed to enroll in a plan prior to retirement. They were eligible to do so, but they didn't. Now, because of that oversight, that failure to "grasp the importance," as Chairman Macy put it, they will be similarly excluded from the protection of the basic hospitalization benefits of the medicare program. These people are few in number. From the beginning, the Federal Employees Health Benefits Act has been subscribed to by more than 90 percent of eligible employees. And of the remaining 10 percent, many are covered by family policy coverage. So we are talking about only a handful of people—only those who failed to enroll before their retirement.

The other day I received a letter from a constituent who is a member of the National Federation of Federal Employees. He said, "It appears that Communists, felons, and Federal employees (those retiring after July 1, 1960) are to be excluded from coverage under the new social security medicare bill. This is, in my opinion, gross discrimination against Federal employees." His statement is true. The only people, other than Federal employees now covered by a health benefits plan and retired employees and their spouses who were at one time eligible to be covered by a health benefits plan—the only people other than these excluded from the basic hospitalization provisions are Communists, subversive felons, and aliens who have lived in America for fewer than 10 years. The bill does not single out anyone else and say "you cannot have hospital benefits under medicare because you have some other insurance, or you could

have had it a few years ago." There are hundreds of thousands of employees of business enterprise in America who have group health insurance policies. They are not excluded. Even the members of the medical profession who will provide the services under this bill, the doctors, dentists, and surgeons, will be eligible for coverage if they are 65 years old before January 1, 1968. Lawyers, engineers, scientists, administrators, corporation presidents, artists, teachers, the poor and the rich, are included under the broad and beneficent provisions of this bill. But Federal employees are not. Federal employees pay about 79 percent of the cost of their health insurance. In private industry, the major businesses pay 50 percent or more of the cost of health insurance plans, and in some cases the employer pays the entire cost. I cannot see the justification for this exclusion.

Mr. Chairman, I strongly urge the committee to consider favorably an amendment to remove this inequity and give coverage under this bill to those who have no other Federal health insurance. The number of people is small, about 20,000 people; the cost is very small in comparison with the bill's cost. These people share common characteristics: they are all old; they are almost all depending on Federal retirement annuities for their livelihood; they all share the common need for medical care in their old age. I hope Congress will recognize their need and will not allow this inequity to become the law of the land.

(The amendment follows:)

AMENDMENT

Intended to be proposed by Mr. Yarborough to 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, viz:

On page 109, lines 14–21, strike out section 103(b)(3) and insert a new section 103(b)(3) as follows:

"(3) upon the effective date of this Act is covered by a health benefits plan under the Federal Employees Health Benefits Act of 1959, as amended (5 U.S.C. 3001–3014)."

NATIONAL COUNCIL OF STATE SELF-INSURERS' ASSOCIATIONS,
New York, N.Y., May 7, 1965.

The National Council of State Self-Insurers Associations respectfully opposes the inclusion of proposed section 303 in H.R. 6675. This section deals with the payment of disability benefits under the social security law. This association would not oppose this section if provision was simultaneously made to offset all benefits payable under the State workmen's compensation laws against the benefits proposed to be paid under the social security law.

The members of this National Council are the Self-Insurer Associations in the States of California, Idaho, Maryland, Michigan, Montana, New Jersey, New York, Pennsylvania, and Utah. The members of individual State associations are associate members of the council.

The 300-odd corporations who are members of one or more of the State associations (and hence associate members of the National Council) all insure their liability under State workmen's compensation statutes and related laws.

Practically all of the large multistate corporations doing business in the United States self-insure their workmen's compensation liability in one or more States and are members of one or more of the State Self-Insurer Associations. Our associate members include, inter alia, the major communication companies and systems, most of the major manufacturing companies, most of the large chemical companies, all of the large steel companies, all of the large automotive companies and all of the large oil companies. The companies which self-insure their workmen's compensation liability employ approximately 10 percent of the total of all persons employed in the United States who come under the protection of the State workmen's compensation laws.

Under the provisions of the present social security law, disability benefits under OASI are payable to a person only if the disability is expected to result in death or to be of a long, continued, and indefinite duration. Under this definition, only cases denominated, in the workmen's compensation field, as total disability cases, presently qualify for social security benefits. Under present

law, because of the repeal several years ago of the provision which provided for an offset of workmen's compensation benefit payments against social security benefit payments, this class of disabled persons now receives double benefits, which, in some cases, exceed the take-home pay of the injured person before his injury.

H.R. 6675 will broaden the class of persons who will be entitled to double benefits by providing for the payment of disability benefits under social security for a covered worker who is totally disabled for at least 6 calendar months, even though it is expected that he will recover in the foreseeable future. The effective waiting period for payments to be received under the new provisions would, therefore, be shortened to 6 months and, after 6 months, the employee would also be paid for the fifth month of disability.

If the aforesaid provisions are enacted into law, individuals of any age now receiving workmen's compensation benefits under State programs for temporary total disabilities, which last 6 months or more, would also be entitled to receive disability benefits under the social security program. Thus the number of persons who would be able to receive double benefits would be enormously increased.

If the principle embodied in the law is carried to its all-too-likely conclusion, the ultimate result could be to transform workmen's compensation into a Federal program and possibly impel the States to repeal their own laws in this area. This result is the ultimate stated objective of some spokesmen for the social security program. The tactic employed to effect this stated objective has not, at any time, been a direct frontal assault, but, rather, gradual encroachment into the workmen's compensation field by means of seemingly minor amendments to the social security law, allegedly improvements therein.

One of the damaging side-effects of these provisions could be the destruction of the incentive for instituting and maintaining industrial safety programs, a trend which could quickly reverse the great downswing in industrial accidents that has occurred in the past 50 years. In the absence of a direct relationship between accidents, costs, and premiums, employers without safety programs and those whose employment is more hazardous would pay no more than employers who have instituted safety programs or whose employment is less hazardous. The anticipated reaction to such a situation is obvious and it could have been an extremely detrimental effect on working conditions throughout the Nation.

An equally serious result of the enactment of these provisions would be that individuals would lose all incentive to return to work or rehabilitate themselves, since the combination of workmen's compensation and social security benefits could, in many cases, give them more than their take-home pay when employed. For example, a married man with two children, earning $5,000 per year, would have a net income after taxes of $4,488. However, assuming maximum workmen's compensation benefits of $60 per week, the same man would receive total tax free benefits of $6,201.60 if the provisions to which objection is made were enacted as part of H.R. 6675 and said person became temporarily totally disabled. It is not likely that such person could be induced to return to work, when able, if his return to gainful employment would immediately result in the reduction of his net income by over $1,700 per annum.

This could, of course, increase, year after year, the class of tax eaters who had been taxpayers. In New York, for example, of those persons classified as temporary disability cases of more than 6 months' duration, 80 percent return to work within a year. How many of this 80 percent will ever return if they can, by continuing their disability, receive more in net income than they would if they return to gainful employment and again became taxpayers?

It seems somewhat ironic, on the one hand, to have the Federal and State Governments spend millions of dollars annually on rehabilitation programs (coupled with the splendid work being done by the President's Committee for the Employment of the Handicapped) and, on the other hand, to have the social security system continue to erode all incentive to return to work.

The House Ways and Means Committee report recommends the passage of the provisions objected to in their current form. It suggests a review of possible duplication between the State workmen's compensation programs and the Federal social security disability program, as well as the effect of costs to employers, after 1966. However, if these proposed provisions are not eliminated now, the possibility of their being removed later seems remote.

For years we have urged the restoration of the offset for workmen's compensation payments against social security only to be met with the adamant re-

fusal of the Social Security Administration to favorably consider the proposal. It is much more likely, therefore, that the States will be forced to cut back their workmen's compensation programs to avoid duplication and overpayment, a result which is both morally and financially wrong.

This association opposes the inclusion in H.R. 6675 of the provisions contained in section 303 thereof and urges that said section be eliminated from the bill.

Respectfully submitted.

JAMES J. REGAN, *Secretary.*

STATEMENT BY THOMAS B. LAWRENCE, WASHINGTON COUNSEL OF THE NATIONAL LICENSED BEVERAGE ASSOCIATION, RE SECTION 313 OF H.R. 6675

Mr. Chairman and members of the committee, the representations herein are made in behalf of the National Licensed Beverage Association. The members of this association are located in 30 States and the District of Columbia. There are approximately 40,000 members consisting of restaurant, tavern, barcafe and cabaret owners, and small independently owned hotels.

Our members are small businessmen. We provide food, beverages, and sometimes entertainment for public and private gatherings. Most of our restaurant and tavern operators have employees who receive tips. There are many problems that our members would encounter should section 313 of H.R. 6675 be enacted into law.

We have been told that withholding taxes on tips from wages would not create a significant imposition and that no responsibility would attach to the employer. We are likewise told that any problems we have in understanding the proposed law will be cleared by the IRS regulations.

However, these assurances of lack of problems do not eliminate the objections which we have to this approach of providing additional social security benefits for tip employees.

We cannot undertake additional obligations. Our members, being laymen, cannot comprehend the complexity of the Internal Revenue Code. They are required to obtain professional advice from lawyers and accountants. They must have this advice from professionals for not only what is actually expected of them initially, but thereafter, in the attempt to comply with these requirements as long as they remain in business. Most of our members are small family businesses and cannot afford additional expense of this type.

An entire new area of recordkeeping and reporting is added to the existing problems. There must be a limit to the extension of these problems. It is believed that the proponents of laws and regulations in this field too often adopt the easy solution of avoiding their problems and adding to ours. They assume that we can and will procure whatever advice we need and that we can and will be able to absorb the cost.

It is suggested that the burden of collecting and enforcing be placed in the hands of the Government where it rightfully belongs and not be shoved upon our members.

An important factor in the suggested approach to the extension of social security coverage to our tip employees is that the employer will be compelled to inquire into the transactions between the waiter and the customer for the Internal Revenue Service. In the past, this was a matter between the customer and the waiter, who operated as an independent contractor. If the waiter gave good service, he received a gratuity. If his service was poor, he might receive nothing. Should section 313 become law, employers would become an interested party in the transactions between customers and employees.

It is submitted, and there is much evidence before this committee, that the employees do not favor the meddling of their bosses in their business.

To treat the waiter, waitress, busboy, etc., in this area as an employee rather than an independent contractor, will create a rash of problems. It would create personnel complications and difficulties between employer and employee. A few of these problems may be carefully considered:

The employer is at a loss as to what to do if some of his employees file statements with him while others do not.

The employer is at a loss as to what to do should he suspect that some of his employees understate tip income while others overstate it.

The employer may feel compelled to discharge a valuable employee whom he suspects does not make an accurate report to him of tip income.

The employer would most certainly be embroiled in controversies between IRS and his employees over the accuracy of their reports of tip earnings.

The employer may be challenged by a discharged employee who could state that the employer's reports did not reflect the amounts of money withheld by the employer for the purpose of this law.

As stated before, employees would be reluctant to report tip earnings, particularly if these earnings are in a handsome amount. They feel that employers may reduce the wages should the tips be substantial.

Employees rarely compare tip income with each other, much less make it known to the boss. Certainly, if the Government experiences difficulty in obtaining accurate statements from employees as to tip earnings, this difficulty would be compounded should the burden be imposed on employers.

Should an employee's paycheck be less than he customarily receives, he will be dissatisfied. His expenses are geared to the wages he receives. It is believed that a large number of employees will seek new employment rather than tolerate the intrusion of the employer in their private affairs.

These are but some of the problems which may be expected if section 313 is enacted into law. We sincerely request that this committee give careful attention to the many potential problems which are inherent to this approach.

An imperfect solution to the problem should not be adopted. There are other possibilities. If the employee desires additional coverage which will provide further security in retirement, the law should make this possible. Employees could certainly include tip earnings as self-employment income. This could be accomplished without involving the employer and all of the problems which would accompany section 313 of the proposed bill.

The members of the National Licensed Beverage Association have full confidence that the committee will give careful attention and study to the difficulties inherent in section 313 of H.R. 6675.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, I deeply appreciate this opportunity to testify on behalf of S. 1125, which is identical with my bill, H.R. 2465, amending the Social Security Act. I am grateful for the opportunity to urge your serious and sympathetic consideration of this proposed legislation because it affects so significantly the lives and happiness of many thousands of our older citizens in my State and in every State of the Union.

I understand that we cannot accomplish in a single year everything that should be done to meet the needs of our older citizens. We are all immensely proud of the progress we have made this year in the effort to bring more adequate hospital and medical care to our retired citizens. But I do not think this great achievement need bar us from proper consideration of a problem that, although it affects only a relative few among our older citizens, affects them overwhelmingly in the last years of their lives.

It is difficult to appreciate at first glance the enormous importance to the people of the provisions of our social security law which reduce the benefits of a widow who remarries after the death of a spouse who was a social security annuitant. The sums the new couple loses are in the $20 to $30 a month range. And this does not appear to be a large sum in a society where the average wage of a production worker in manufacturing is well above $100 a week. But the people with whom I am concerned here today do not share in this general economic prosperity. Indeed, many of them would meet the technical definition of poverty stricken, even without the loss of this $20 to $30 a month.

What most of these couples receive is exceedingly meager. A widow of a social security annuitant currently receives an average of only $67.85 a month and at most only $80 a month. The loss of $20 to $30 from this tiny sum as the price of remarriage makes the decision to remarry or not a major financial decision instead of simply a human decision based upon affection and a desire for companionship in her remaining years.

The Social Security Administration has acknowledged that the change in our social security law embodied in S. 1125 would involve additional costs that would be "very small, even negligible" in terms of the entire system. The major objection is that a couple involving a widow who remarried under the provi-

sions of this proposed legislation would receive greater combined benefits than a couple in which no remarriage was involved.

This inequality in benefits is acknowledged. But in my opinion it would not result in a significant inequity under our social security system. To those retired persons fortunate enough to retain their spouses, the limited amount of their social security benefits is an ever-present fact of life and often a source of legitimate discontent. But these couples are not forced to face the acute agony of choice that is required by our present law of those who wish to remarry after having lost a spouse.

It s this agony of decision—or the no less painful acceptance of an alliance not countenanced by our social conventions and ethical standards—that, in my opinion, gives the situation of these couples its special character justifying special treatment under the law.

I do not believe we have a right to require our elder citizens to pay this price in real sacrifice of their living standards or be forced to live along for the rest of their lives. I do not believe those social security annuitants who have been fortunate enough not to lose a spouse want us to deny this relief to the less fortunate in this regard.

There is increasing understanding, I believe, of the special character of this problem and of the need for appropriate and prompt relief. I have been informed by the Library of Congress that between January 1 and April 15 of this year a total of 42 bills of identical or similar nature have been introduced in the House and Senate to deal with this problem.

I am especially happy that bills identical to my H.R. 2465 have been introduced by Senator Hartke and Senator Moss and by the following Members of the House of Representatives: Melvin R. Laird, Sam Gibbons, Thaddeus J. Dulski, James Kee, Robert E. Sweeney, Charles H. Wilson, Tim Lee Carter, John E. Fogarty, Augustus F. Hawkins, Abraham J. Multer, Herbert Tenzer, E. S. Johnny Walker, Robert L. Sikes, Leonard Farbstein, Roman C. Pucinski, John J. Duncan, Thomas P. O'Neill, James C. Corman, William T. Murphy, Arnold Olsen, Thomas C. McGrath, Ralph J. Rivers, Henry Helstoski, D. R. Matthews, John V. Tunney, Chet Holifield, Spark M. Matsunaga, Philip J. Philbin, William D. Ford, Michael A. Feighan, John R. Hansen, Ken W. Dyal, John A. Race, and Jonathan B. Bingham.

I am also very gratified to report that numerous other Members of the Congress have told me that they will support this legislation when it comes to the floor.

I cannot urge you too strongly to give favorable consideration to this legislation in the interest of these retired citizens who deserve all the peace and happiness we can give them in the twilight of their lives.

A STATEMENT BY WILLIAM VROMAN, PRESIDENT, YOUNG CITIZENS COUNCIL

A YOUNG TAXPAYER'S VIEW OF H.R. 6675

My name is William Vroman. My residence is 823 West Lincoln Highway in De Kalb, Ill. I hold the office of president of and am testifying for the Young Citizens Council. It was incorporated in Illinois during February 1965. Our first corporate meeting was held on April 28, 1965. Prof. F. G. Dickinson is our adviser and mentor.

The goal of the Young Citizens Council is to help in the nonpartisan struggle to educate the American people to the implications of shifting the tax burden every payday to the young, and especially to help in the struggle to freeze social security taxes on the young. I am age 25 and have the viewpoint of a young man.

Since our formation we have received publicity and mail from as far away as Massachusetts, New York, Nebraska, and Tennessee. We are now corresponding to start chapters in those States. Contributions to our financial base have come from the very wealthy and the very poor, from the very young, and the very old.

We do not, gentlemen, wish to appear selfish in our concern for the young. We fully acknowledge the plight of other groups of our population. But we feel that the young have been taken to the cleaners as a group to pay for the windfall benefits to the rich old.

As an example, please look at table 1 on page 252 of the report of the Committee on Ways and Means. Table 1 shows the burden which has been shifted right

to the young's shoulders. Of the $140 billion needed to take care of all individuals over the age of 50 years until they die, only $7 billion will be prepayed—thus making a $133-billion windfall. Those people in the limelight of life (50 to 65 years), and in higher salary brackets, will pay the $7 billion and get $105 billion in return.

Relative hospital benefit cost and taxes paid under H.R. 6675, by selected age groups over 50 years of age

	Cost of providing hospital benefits to selected age group	Taxes paid by selected age group	Cost younger workers are required to pay to provide benefits to selected age group
(1) Individuals 65 or over on Jan. 1, 1966	$35		$35
(2) Individuals between 60 and 65 on Jan. 1, 1966	25	$1	24
(3) Individuals between 50 and 60 on Jan. 1, 1966	80	6	74
(4) All individuals 50 or over on Jan. 1, 1966 ((1) through (3) above)	140	7	133

From this table we can see that today's young will have to pay the bill—unless we, in turn, stick the next generation and I do not believe we will. Implicit in the statement is the fact that we will overpay for our own benefits.

Under new bill H.R. 6675, employee-employer retirement contributions for the 18-year-old, at 4¼ percent compound interest, would total $84,300. Including the 7-percent increase in benefits for which H.R. 6675 provides the total cash benefits this work could actually collect after age 65 is $25,802. This sum would allow a young man to pay an annuity from a private insurer which would give him $634 per month for life. Under social security the maximum allowable is $312 per month for life.

In many cases old age has been unkind to the over-65 group. Either sickness or financial woes late in life have left them near penniless in a nonearning part of their life. This destitute condition should not be allowed to exist in America. We advocate complete care of these people at the expense of the working and hardy members of society.

We do not subscribe, however, to the flagrant waste of worker's money to support those fully capable of supporting themselves. We will leave it to other groups to supply statistics on this theme. Whether only 25 or 50 percent of the people reaching 65 need assistance is not the question. The important feature is that H.R. 6675 does not take this fact into consideration. By not acknowledging this you are committing an act of immorality. Immoral in what sense? When something is taken forcible, as are taxes, and then waste ensues—this is immorality in the strongest terms.

The remedy is simple. It involves adjusting the tax rates, invoking a means test, and not jeopardizing social security with giveaway programs like H.R. 6675. The most important change which is required is, a change in the concept of a flat tax rate on every working person in the society. We feel there are equitable methods of taxing for a program like social security.

Private insurers recognize the fact that when a person is young he is less susceptible for sickness. Accordingly, his rates are initially smaller, then they increase as he progresses through the years. This is equitable and just. Seldom does a man grossly overpay a private insurer.

When a young man is in the early adult years of life he is struggling for his place in the sun. He is trying to provide enough money for food on the table each day, shoes for the baby, payments on the house, plus trying to save a little for the children's education and old age. There is not much left after.

As he gets older, hard work has increased his salary thus edging him away from the brink of bankruptcy. He successfully gets his children through school and is able to put a larger portion of his salary in the bank. Why? Because there isn't that extra pair of shoes to buy, and the last payments on the house

have been or will be paid shortly. Now he and his wife begin looking forward to retirement.

To account for these facts, gentlemen, we advocate a holding of the tax rates on the young. The following schedule will picture a stairstep formula for you.

The stairstep formula

Age	Tax rate (percent)	Tax base (1966)
Under age 35	2	$5,600
Ages 35 to 50	4	5,600
Ages 50 to 66	6	5,600

We believe this will provide sufficient revenue for the program. There will be less incentive to give windfall, "waste" benefits to woo voters. It will provide an equitable system under which social security might work for many years to come.

I have delayed, to this point, reiterating part of Dr. Dickinson's testimony—the important theory which deals with the inexorable tide of social evolution. I have supreme confidence in the coming "younging of the electorate." This confidence urges the feeling that social security and welfare schemes for the rich and middle income old will all be set aside by the elected officials of the populace—or they will be voted out of office.

We advocate, as I mentioned earlier, taking care of the old via a program as social security. But a rising tide, gentlemen, angered by inequities does not often stop at correcting deficiencies. The stop, as you know, seldom occurs before the total destruction of the inequitable system.

You wouldn't want to be guilty of formenting such a catastrophe; I wouldn't want to be part of such an action. But you will be and I will be unless you modify this law and redesign social security to be moral and equitable.

STATEMENT BY FRANK G. DICKINSON, ON BEHALF OF THE YOUNG CITIZENS COUNCIL OF DE KALB, ILL.

THE PRESENT POSITION OF SOCIAL SECURITY IN SOCIAL EVOLUTION

Preamble

My name is Frank G. Dickinson. My office address is Department of Economics, Northern Illinois University; my residence address is De Kalb, Ill. Obviously, I cannot testify for a university. These ideas are my own. My statement is made on behalf of the Young Citizens Council of De Kalb, Ill., a new organization chartered February 24 under the "General Not for Profit Corporation Act" of Illinois. With me is H. William Vroman, one of my graduate students at Northern Illinois University, De Kalb, Ill., who is the first president of the newly organized Young Citizens Council. Mr. Vroman's statement will explore some of the obvious ways in which this measure exploits the young; and tell you about their new organization.

I have testified on pension questions during the past 10 years several times before the House Ways and Means Committee; and before this committee on H.R. 10 (June 18, 1959, when I suggested alternate limits for the pension set-aside for the self-employed of 1 percent or $1 a day). Today, I hope to help the members of this important committee, of which both Senators from Illinois are members, strengthen social security and understand the importance of amending this measure to make it fair to the young. I shall stress taxes and not benefits. I shall stress the stake of the young in this bill.

I propose, with the consent of the chairman, to shorten my usual lengthy presentation by asking the chairman to allow me at certain points in my testimony to summarize certain of my more than a score of published items—only my own studies will be featured because this is my testimony—on pension questions by inserting in the record of these hearings the full text of these items without

reading the entire text of each; nor the long footnote listing them. Mr. Chairman, I trust that you will include those four items in the record of these hearings.[1] (The attachments referred to were too voluminous for printing in this record and were made a part of the Committee files.)

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[1] I shall refer you to the following of my published items; some of these, but not all, I ask to be placed in the record:

(*a*) "The Social Security Principle," Journal of Insurance, December 1960. I explained that the social security principle was the principle of fraternal assessment insurance, popular at the turn of the century. I contended that the OASI Trust Fund had degenerated into a claims fluctuation fund and that only 4 percent to 5 percent of the pension benefits had been prepaid in retrospect at the time the individual entered on his OASI pension, and that the OASI Trust Fund no longer could pay the benefits of the next 20 years. The lesson from the fraternal experience was that to protect OASI from such a fate, there should be three stairsteps in the OASI taxes—under age 32, age 32–46, age 47 and over. This first article in the series was reprinted in the hearings before the Committee on Ways and Means on H.R. 4222 (Aug. 1, 1961) in my testimony of 39 pages, 1256–1294. Hence, there is no need to reprint this first article again.

(*b*) Thus OASI resembles OAA to the extent of about 95 percent. According to pages 69, 70, and 71 of "Social Security After 18 Years," a staff report to Hon. Carl T. Curtis, chairman, Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, 1954, the unprepaid portion of OASI benefits was 98 percent at the end of 1952; if employer contributions were included, 96 percent. In my opinion, the committee should bring the Curtis study down to date. Second, a letter dated September 22, 1964 from Robert J. Myers, Chief Actuary of the Social Security Administration, included a manual entitled "Work Book—Basic Training Course for Technical Employees, Office of Employee Development, Division of Management," in which Mr. Myers indicated (on p. 44) that in 1963 that "* * * for those now on the rolls it is likely that they would have paid, at most, for about 10 percent of the benefits actually payable to them." This indicates a current upper limit of 10 percent prepaid. (I have exchanged a number of letters with Mr. Myers.) According to my computations, only about 5 percent of the benefits have been paid on date of retirement. The Curtis type study and the Myers' "upper limit" study should be updated for students as well as the Members of the Congress. Under the proposed bill the percentage of public charity (or "social" charity) will rise above 95 percent for those of us already past 65 years of age.

(*c*) My first article was, in turn, criticized in the Journal of Insurance, June 1961, by three actuaries (W. R. Williamson, Ray M. Peterson, and Robert J. Myers), with my rebuttal. This item was also reprinted in my testimony on H.R. 4222 and will not be among the items I am asking to be inserted in the hearings today.

(*d*) My discovery of "The Century Cycle" was announced in a 28-page article under that title reprinted from The Proceedings, 1963–64 of the Conference of Actuaries in Public Practice, pages 365–392. (This article is actually taken from the manuscript of my forthcoming book entitled, "Time and Man; The Revolt of the Young in the Century Cycle.") Briefly, "The Century Cycle" refers to the fact that the percentage of voters aged 50 and over in the United States has risen from about 25 percent in 1900 to the century peak of about 42 percent in 1964, and will return to 25 percent again in the year 2000. The percentage of adults 50 years of age and over in 1964 was close to 40 percent whereas the percentage of voters was about 42 percent. This difference results from a preponderance of young adults among the adults who are ineligible to vote—the aliens, the persons made ineligible by change of residence, etc. In my testimony, I shall comment on the 28-page reprint and ask that it be included in the hearings today. It is basic to my testimony.

(*e*) I also ask to have reprinted in the hearings today a four-page item also entitled "The Century Cycle." It is largely excerpts from the 28-page article of the same title; it was prepared by the editors of The Spectator, a well-known insurance journal since 1860, published in Philadelphia. I have attached to the four-pager a single sheet in the form of a letter on the subject, "The Road Ahead;" this one-page letter is dated Thanksgiving Day 1964; it is, therefore, a sort of appendix to the four-pager.

(*f*) I exchanged some correspondence with Hon. Wilbur D. Mills, chairman, House Committee on Ways and Means. The letters from Mr. Mills are dated February 10 and April 26. My reply to Mr. Mills is dated Sunday, February 14; it runs about 4½ typewritten double-spaced pages (large type) and is divided into three parts: the impractical, the practical, and the very practical. These three parts summarize the ideas mentioned above and lay stress on the need to strengthen social security and lessen the burden of social security taxes on the young, say, those under age 35. This exchange of letters is set forth in the text of my testimony today. It summarizes the testimony I wanted to give before the House Ways and Means Committee.

(*g*) All persons hope and some actually expect length of life measured from birth to increase as rapidly during the second half of the 20th century as it did during the first half. Unfortunately, that expectation is not supported by the population mortality tables from 1950 through 1963. The three opening paragraphs of my article, "The Century Cycle"—which I requested in footnote (*d*) above be inserted in the record of today's hearings—suggest that the gain in the second half of the 20th century will be only 7 years as compared with almost 21 years in the first half of the century. I hope these three paragraphs will suffice to eliminate any notion that the rapid gains of the past will be continued in the future. Upon request, I would be glad to furnish any member of the committee with a copy of the article referred to in the first paragraph of "The Century Cycle," which was also presented before the Conference of Actuaries in Public Practice, but in 1950. I doubt that the detail is sufficiently important to warrant the insertion of my 1950 paper, "The Threescore-Year-and-Ten Plateau," as the committee probably realizes that gains in the expectation of life at birth will be very modest during the third third of this century. An era has ended, making the first half of this century perhaps mankind's greatest half century. We cannot attain, for example, a negative rate of infant mortality to duplicate the decline percentagewise of the first half of this century.

(*h*) A new organization in Dekalb, Ill., the Young Citizens Council, was chartered recently by the State of Illinois under the General Not-For-Profit Corporation Act—charter

After this long footnote, I return to the text of my testimony under the title, "The Present Position of Social Security in Social Evolution." I will first review the four pages of testimony I wanted to present to the House Ways and Means Committee. Mr. Chairman, will you please distribute to the committee at this time the exchange of letters with Hon. Wilbur D. Mills? I shall read and comment on my reply of February 14.

FEBRUARY 10, 1965.

DEAR PROFESSOR DICKINSON: If you would make available to me the four-page letter to which you referred in your letter of February 6, I shall make every effort to have it presented to the committee during the current executive sessions on H.R. 1.

With kindest personal regards and best wishes, I am,

Sincerely yours,

WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
House of Representatives.

No. 290 dated Feb. 24, 1965. The officers of this new organization are three students at Northern Illinois University: H. William Vroman, president; Donald Udstuen, first vice president, and Wesley Johnston, secretary-treasurer. I have been asked to serve as the advisor for the Young Citizens Council. Mr. Vroman and I appear here today before the Senate Committee on Finance as representatives of this new organization. The purposes of the Young Citizens Council are set forth in two items which I wish to place in the record today: first, my letter to Mr. Vroman of March 26; second, an editorial of Wednesday, April 27, "Young Citizens Rebel," in the Chicago Tribune.

(i) I would also like to call attention to the editorial, "Robbing the Young To Pay the Old," by Charles B. Shuman, president of the American Farm Bureau Federation, in the March 1965 issue of Nation's Agriculture. Since Hon. Charlotte T. Reid, Member of Congress, the Representative from our district, has already inserted this editorial in the Congressional Record (March 22, p. A1314), I shall not ask that it be made a part of the record of the hearings today.

(j) The change in the age distribution of voters during this century is due to four factors: changes in birth rates, changes in immigration and emigration, and changes in the length of life (mortality); the fourth, the changes in the proportion of the adults ineligible to vote, affects changes in the percentage of older and younger voters but not younger and older adults. No attempt will be made in this testimony to treat these four factors separately. For example, expectation of life at birth, sometimes called average length of life from birth, has remained almost stationary around 70 years for the past decade. As noted, some of us doubt that it will exceed 75 years by the end of the 20th century. We surmise from the available data, that the proportion of voters aged 50 and over was 25 percent in 1900, hit the century's peak of 42 percent in 1964, from which it will steadily recede to 25 percent again at the end of the 20th century. (Those under age 50 are called herein young voters or merely, the young.) This is what we mean by "The Century Cycle," but we shall omit the statistical evidence.

(k) In the text I have made frequent reference to the term "the younging of the electorates." I am sure you will not find the word "younging" in your dictionary but you will find the opposite, "aging," in any large dictionary. I thought I should offer the committee the first article I wrote (in 1958) in which I coined this term "younging." It was the result of 4 months study in Australia and New Zealand and refers mostly but not entirely to those two countries. At that time I thought that the changeover from the aging to the younging of the electorate would take place in New Zealand in 1962. On the basis of later, detailed data furnished me by a former Prime Minister, the careful computations of the government statistician of New Zealand show that the proper year was 1964 instead of 1962, as I showed in this eight-page article which I would like to have inserted in the record. I daresay that anyone who wishes to study this important change which is now coming in Western nations would do well to start with this 1958 publication. It also includes an editorial of the same title. In fact, I would say that anyone who wants to look clearly into the dynamics of social change among Western nations would do well to watch Australia and New Zealand.

As noted elsewhere, the changeover from an aging to a younging electorate will not come in the United Kingdom and Sweden before about 1980. Hence, according to my reasoning, the "welfare state" trends will continue in these two countries until around 1980. So I would like to have this short article of eight pages inserted into the record in the hope that it may add to the knowledge of the members of the committee and other Members of the Congress who are called upon to judge some of these great changes in social evolution.

I readily grant that some of my concepts about social evolution are result of reading the many writings of Thorstein Veblen who died in 1929. (I think it likely that the junior Senator from Illinois might have known Professor Veblen personally; I did not.) He had a reputation of being a rather cantankerous economist but his writings on social evolution are among the best. I daresay that he had a better understanding of the implications of Charles Darwin's, "The Origin of the Species," and his fundamental doctrine of evolution than did any other social scientist; also Veblen accomplished more than any other economist in applying the Darwinian Theory of Evolution to the social sciences. I am especially indebted to Veblen for pointing out again and again that every stage in social evolution begins and ends. It is my belief that one stage in social evolution, the aging of the electorate, is now in the process of ending in Western countries. Secondly, I am of the opinion that it was the aging of electorates which largely accounted for the widespread acceptance of "welfare state" ideas among the Western countries in the 20th century, particularly in the second third of the 20th century.

(l) To summarize this long footnote—I am asking that the record of these hearings include four of my published articles described in footnotes: (d) "The Century Cycle" of 28 pages; (e) the five pages, the short version of "The Century Cycle"; (h) my letter to the new Young Citizens Council and the editorial about its birth in the Chicago Tribune of Apr. 7, and (k) my 1958 article of 8 pages, "The Younging of Electorates."

NORTHERN ILLINOIS UNIVERSITY,
De Kalb, Ill., February 14, 1965.

Hon. WILBUR D. MILLS,
Chairman, House Committee on Ways and Means,
House Office Building, Washington, D.C.

DEAR MR. MILLS: Thank you for your reply of February 10. I trust that reading aloud these four pages will prove valuable to the committee members.

My statement is divided into three parts: the impractical, the practical, and the very practical.

Cordially,

FRANK G. DICKINSON, *Professor.*

APRIL 26, 1965.

DEAR DR. DICKINSON: In reference to your telegram, generally speaking I do not insert in the record statements submitted on subjects pending before the Committee on Ways and Means. I am sure you can understand the reasons for my policy on this, since presumably there would be many people who would like such statements inserted in the record.

If, as you indicate in your telegram, Mrs. Reid should desire to insert your letter in the record, this would be perfectly all right with me.

Sincerely yours,

WILBUR D. MILLS,
Chairman, House Committee on Ways and Means,
House of Representatives.

The impractical

In my last appearance before the Committee on Social Security Amendments (H.R. 4222, August 1, 1961) I said at the very end of my remarks (39 pages, vol. 2, p. 1294): "God willing, if I should live to be old enough to get my OASI checks, I will keep only the January check; for that is about what my employer and I have prepaid. The other 11 monthly checks, I will give to youngsters who must pay for my benefits. If some great catastrophe should pauperize me, I will use as many of the other 11 checks as my circumstances require, and be grateful for them as public charity." This is what I meant then and mean now by a friendly attitude toward social security coupled with a reasonable standard of social morality in an era of the aging of the electorates, which is now ending.

Some of you may possibly recall that in 1954 I issued a call for a society of "go-givers" who would agree to refrain from accepting OASI pensions in excess of the amount the individual and his employers had prepaid. I did not get much of a response to that appeal. So I am calling this first part of my remarks, "the impractical."

Now you propose to increase my social security pension by about $7 a month. I expect to retire from teaching on September 1, 1967, at which time I will be eligible to receive my OASI benefits. I shall apply the same rule to this extra $7.

Now you also propose to offer me certain types of hospital care and nursing home care which have been estimated to pay, on the average, something like 28 percent of the health cost of a person 65 years of age. This is a nontransferable service benefit. I will pay nothing toward the cost. I can, of course, give away $3,000 a year for 10 years as penance. (I started last year.) Unless I become one of the truly needy old, I shall not accept such service benefits. Also, I will not stain the word "insurance" by calling such a promise insurance. This is another tax-welfare program, not an insurance program.

In passing, let me admit that Congress has a perfect right, of course, to lend any name that it wishes to legislation, and will frequently choose words that have the greatest selling appeal. I do not have the advantage of a retrospective view which an economist would have in the next century. He could then look back, particularly at the middle third of the 20th century, and might then conclude that it was wise to call such a tax-welfare program (now about 95 percent public charity), "insurance," in order to get the proud American people to accept the nonprepaid benefits. I admit that, in retrospect, an improper label for legislation sometimes seems wise. The middle third of our century did witness probably the most rapid aging of any population in history. On the other hand, the greatest relative gain in affluence came during this middle third to those now in the age group 65 to 75 or 80.

The practical

Now for the practical. An individual cannot grow younger, but our Nation is growing younger. We have just passed the peak of the century cycle in the pro-

portion of older voters—aged 50 and over—at about 42 percent. At both the beginning and the end of the 20th century the proportion was and will be a modest 25 percent.[3] This downswing will be a practical discovery for political leaders—and for preachers, physicians, philosophers; even poets and economists. Dr. Townsend and J. M. Keynes will be out of style in the third third of our century. The young will be in the driver's seat within less than a decade.

All we know about social evolution is that every stage begins and every stage ends. The central force that produced what the British like to call the welfare state in the second third of the 20th century in Western nations was primarily the aging of the electorate.

I admit that prophecy is still an exclusively divine gift. But I think there are some things that we can say about the third third of the century which, if not completely realized, will, nevertheless, be of great practical value to our political leaders today.

First, I doubt very much that it will be a third of a century in which the Federal budget will be unbalanced in three-fourths of the years. I do not think you should look forward to the third third of the century as an era in which it will be unpopular for political leaders to balance the budget and pay off some of the national debt.

Second, the young, as I have known them as an old teacher, do not want to live in a riskless society. Youth is a bit reckless; the young do like to take some chances. They are not stupid, unable to detect being exploited. All of the young do not have poor grandmothers and poor grandfathers that must be looked after; and all of the old do not have grandchildren. So as the young come to rule, they will surely annihilate the welfare state concept which has developed during the second third of the 20th century for the basic reason I set forth above, the aging of the electorate. The welfare engine is now in reverse gear.

Third, a similar switchover from the aging to the younging of the electorate will not come in the United Kingdom, Sweden, and other nations until around 1980. Hence those countries provide us with no harbingers of our own future. Those nations will and must continue their welfare state era until 1980. Only Australia, in which the younging of the electorate has already started gives us a sense of history. The welfare state wings of the labor parties down under are slowly fading.

Fourth, just consider the increase in the number of persons reaching age 21 in each calender year in the United States--from 2.2 million in 1960, 2.8 million in 1965, 3.5 million in 1970, 3.9 million in 1975, and to over 4 million in 1980 and 1985.

Thorstein Veblen

I admit to students of economics that I am indebted to Thorstein Veblen for some of these ideas on social evolution. Starting at the turn of the century, he taught us more clearly than perhaps any other institutional economist that social evolution is continuous, that any two-step concept such as Karl Marx suggested in the rule first of the bourgeoisie followed by the rule of the proletariat is an inaccurate presentation of social evolution, because every stage in social evolution begins and ends. One stage is ending now. Again, it is my hope, gentlemen, that this reference to the permanence of social evolution will help to guide you out of the second third into the third third of the 20th century.

My principal hope is that the switchover or switchback from an aging electorate to a younging electorate, which has never occurred before in the history of the world, will encounter the least possible amount of confusion, the least possible rigors of a class struggle, and the gentlest of relationships between the old and the young. The time has gone by for us to still think in terms of giving a lot of money to the old people like myself, and the rich old, by taking it out of the pockets of the young through OASI, Federal deficits, and lower taxes. These are correctly called transfer payments from the young to the old. They take place every payday, not during some ill-defined generation. It is somewhat like taking

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[3] I can furnish you, Mr. Mills, with the necessary tables derived from census data. The voters who will become eligible to vote at age 21 in the year 2000 will, of course, be the survivors of the babies born in 1979. The brandnew voters attaining age 21 in the year 1985 were born in 1964; they have all been counted. So the proportion of older voters will definitely be declining between now and 1985. This downward trend in the proportion of older voters will, I believe, continue beyond 1985 to the end of the century. The females who are going to bear children in 1965 to 1979 have already been born and counted. But we do not, of course, know what the birth rates will be from 1965–79. My forecast for 2000 assumes an average of 4 to 5 million births a year through 1979. The number of births in 1965 and 1966 could fall below 4 million.

money out of one pocket and putting it into another; but, gentlemen, they are not the same pair of pants.

The very practical

Last, the very practical. For these reasons, so briefly and ineptly stated, I urge you to freeze social security taxes at the present level until the taxpayer attains age 35, even if a higher tax schedule is required for those who will pay 30 or fewer years. He would still have to pay social security taxes many more paydays than I have. Give the young a chance. You may need the support in the near future of this coming torrential horde of young voters. Perhaps as the years go by some of the members of the committee will thank me for the information in this statement.

Finally, a brief comment. Inflation cuts several ways. As indicated above, the great majority of the old in the age group 65 to 80 are middle class. Inflation has increased their current cost of living (usually without dependents), enabled them to sell advantageously houses owned for 30 years, investments held for 20 years, etc. Inflation has increased the gross national product and their share of it. But the transfer payments from the rich and poor young to the rich, middle income, and poor old are independent of the amount of GNP—$333 billion, $666 billion, or (the automation) $999 billion. The young, as always, will gladly help the old and the young who are truly in need regardless of inflation, GNP, etc.

My conclusions

So much for the materials sent to the Honorable Wilbur D. Mills, chairman of the House Ways and Means Committee. I now present my conclusions.

Over the years, my students have told me that when I try to be brief I tend to be dogmatic. But I must take that risk today. I have sought to take the committee today on an excursion into the field of social evolution and try to locate social security and this particular bill in that never ending process. Every stage of social evolution begins and ends. One is ending now. That makes the answer to the question posed by the title of my remarks very difficult for me and for you. We live in revolutionary times. I cherish the hope that I have kept this discussion today on a high plane. But the several conclusions and the suggested amendment may seem dogmatic to some members of the committee. Such is not my intention.

My first conclusion is that this bill, H.R. 6675, belongs to the second third of this century. Social evolution has passed over Dr. Townsend and J.M. Keynes. This bill, in other words, perhaps fits the second third and not the third third of our century.

Second, watch out for the avalanche of the young in the third third of this century. You can keep out of its way, but you cannot fight it. The young will rule. The young will revolt against these huge transfer payments from the rich and poor young to the rich and middle-income old.

Third, the power to tax is inherent in the sovereignty of the Federal Government. It is a sine qua non of sovereignty. The Federal Government can impose on earners at all ages the same rate of social security taxes. The fraternal assessment societies, popular at the turn of the century, charged all "brothers and sisters in the lodge" the same assessment rate. They had the power to make this fatal mistake. All of them went bankrupt except the few which saw the handwriting on the wall and charged younger "brothers and sisters" lower assessment rates than older "brothers and sisters." By that change, a few avoided bankruptcy.

Fourth, the sovereign power of government cannot prevent social security from going down that same rocky road, because the right of the young to revolt against these huge transfer payments from the rich and poor young to the rich and middle-income old under uniform tax rates, is just as inherent in a democratic society as is the sovereign power to tax. The people are the sovereigns. I beg you to eliminate this basic inequity of charging young people every payday as much social security taxes as you charge older workers who will pay many fewer years.

Fifth, social security is not really a system but a series of layers of benefits started in 1935, changed in 1939, and six times since then. Social security is like a series of ledges on a hillside. Trying to treat social security as a hill or as a system completed in a given calendar year and referring to the cost to the available taxpayer—does not exist except in the Keynesian wisecrack that "in the long run we are all dead." In any month, in any year, there are taxpayers

at all earning ages. This wisecrack was the most revealing error made by the late J. M. Keynes (who was never a professor).

Sixth, the era of Dr. Francis E. Townsend and J. M. Keynes has ended. During the third third of the 20th century, leaders will be anxious to pay off the Federal debt, reduce the social security taxes on the young (say, those under 35 years of age), and generally favor the younger voter.

Lastly, gentlemen, these are my conclusions from my study of social evolution and of the implications of the switchback from an aging electorate, which largely produced the "welfare state" trend, to the brandnew era of the younging of the electorate. In other words, gentlemen, I believe that H.R. 6675 clearly belongs to the second third of the 20th century and not to the third third. It represents a look backward and not forward in social evolution. Finally, as an old teacher, let me venture the observation that the young will never rebel against reasonable provisions for the needy old and the needy young. The coming revolt of the young will be against the transfer payments from the rich and poor young to the rich and middle-income old; and to the mounting Federal deficit, so popular in the second third of this peculiar century. The transfer payments to which I refer are made every payday with some adjustments made on April 15.

Freeze social security taxes until age 35

I have made some critical remarks about H.R. 6675. Now I will propose an amendment which will give you a chance to criticize me. First, let me apologize if any of my criticisms are overly sharp. I mean to help you strengthen social security, not weaken it. Its friends are far too few. Not once have I mentioned such extreme terms as the "population explosion" and the "revolts on the campuses." I apologize for a few references to an unpleasant term, "welfare state" of British origin. I dislike these flamboyant terms. (Nor have I referred to the $40 billion deficit in your own civil service retirement reserve funds.) But I have tried to be explicit.

I respectfully urge the committee to amend this bill so as to freeze social security taxes at present levels until the taxpayer attains age 35. Give the young a chance to get started raising their families. Do not require a majority of them to pay more social security taxes than income taxes. Those who must pay many years should pay less each payday. Do not aggravate the coming revolt of the young. Do not endanger the future of social security.

I am not commenting today on the benefits, the welfare side of this vast tax-welfare program started in 1935. My proposed amendment, in order to be responsible, must provide for revenues to match the revenue loss resulting from my proposed tax freeze below age 35. First, you will need to obtain actuarial data from the Social Security Administration. Second, I would prefer two stairsteps of higher taxes and tax rates—first, for ages 35 to 49 and, second, for ages 50 and over. I would prefer not to guess whether these two extra rates would be 0.2 and 0.4 percent, 0.4 and 0.8 percent, etc. These two extra rates can be computed quickly by the actuarial staff. The committee should also request figures for a one-step-higher tax rate for all ages, 35 and over. Then the committee would be armed and could then chose between the two stairsteps and the one stairstep in the social security tax rates. Again, I suggest two stair steps for the age-35-and-over group, but two might seem too difficult to administer. Those now age 50 and over and those 35–49 would pay higher social security taxes until retirement than under present law or under the proposed new (uniform) tax rates. Likewise, my stairstep taxes would require lower lifetime taxes for those now under age 35—unless some new sinkhole is invented to siphon off the extra contributions from those now 35–49 and those now 50 and over under my proposed stairsteps. Please don't be fooled by any specious argument that my stairsteps will not help those under age 35 during their working lifetimes. Either one or two stairsteps for the 35-and-over group would be a mild reform, only a step in the right direction away from the fatal fraternal assessment idea of charging all "brothers and sisters in the lodge" the same assessment rate.

The "stupid" young and the "greedy" old

Is this entirely a contest between the greedy rich and the greedy middle-income old 50 and over versus the stupid rich and poor young? Of course, all of the rich and middle-income old are not greedy, and all the rich and poor social security taxpayers under age 50 are not stupid. On this point I recall a vivid comment of a rich Wall Street lawyer (over 70). "Dr. Dickinson, I need my OASI pension

checks to help pay my income taxes during retirement. I doubt that I will prepay even your 5 percent of the cost. Of course, we are robbing the young every payday through uniform social security taxes, through not paying enough taxes to balance the Federal budget, etc. We should admit it. But tell your young friends that they can get even. Tell them to go and do likewise to young who follow them" I call this "the treadmill of time ad nauseam, ad infinitum."

Senator Byrd, and members of the committee, I have pointed out how the American people, both young and old, can slow down a little this "treadmill of time" by freezing social security taxes at present levels for taxpayers under age 35 and increasing the tax rates by one or two stairsteps above age 35. The coming avalanche of the young will force a slowdown in this "treadmill of time." Why not now? Thank you.

WEST VIRGINIA STATE MEDICAL ASSOCIATION,
Charleston, W. Va., May 14, 1965.

Hon. HARRY F. BYRD,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: As chairman of the Council of the West Virginia State Medical Association, I desire to express to you the following views regarding H.R. 6675 now before the Senate Finance Committee.

(1) The King-Anderson portion of this bill makes no distinction between the individuals above the age 65 who need financial help for hospitalization and nursing home care, and those who have financial security and are fully able to meet their expenses. This is a waste of the taxpayers' money, and places an unnecessary burden on the younger group of wage earners.

(2) The medical services of private physicians should not be placed under the complete control of the hospitals or under the Department of Health, Education, and Welfare. The "Douglas amendment" is an attempt to do this in the Senate. The four branches of the private practice of medicine with which this amendment is concerned are pathology, radiology, anesthesiology and physical medicine. The services of these physicians are not hospital services as such, and have no place in this portion of the bill.

(3) I am confident you are concerned with maintaining hospital and medical costs as low as possible compatible with good medical practice. The approval of that portion of H.R. 6675 as now written pertaining to the separation of physician's services from the hospital benefits portion of the bill, would tend to lower the total costs of medical care. Combining these physicians' fees with the hospital charge, as would be required if the "Douglas amendment" is approved, would obscure and hide the hospital profit in these departments.

(4) The number of physicians in all branches of medicine mentioned above. The adoption of the "Douglas amendment" would only make this shortage more acute, as there will be fewer physicians electing these specialities during their training years. In addition, there are numerous physicians now practicing these four specialities in hospitals who will separate themselves from present hospital agreements because of probable exploitation by hospitals.

I sincerely hope that you will use your influence and vote in the Senate to defeat those ill conceived, costly and disruptive portions of the proposed "medicare bill" as outlined above. I would greatly appreciate hearing from you.

Very sincerely yours,

CHARLES L. GOODHAND, M.D.,
F.A.C.S.

STATEN ISLAND, N.Y., *May 1, 1965.*

Hon. H. F. BYRD,
Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: The House-passed medicare bill (H.R. 6675) does absolutely nothing to encourage people to cultivate good health so that they will not require medicare when they retire. The enclosed sheet (new approach for medicare), will do just that by providing a real incentive. Certainly a plan

which will do so much to bless the individual as well as our country, ought to e given a favorable hearing by the Senate Finance Committee. Then the Senate will be able to constructively amend and improve the action of the House on medicare.

At a time in our country's history when so much stress is placed on freedom, individual enterprise, civil rights, and the use of the ballot, this plan (new approach for medicare) is indeed a real opportunity to exercise these principles and to honestly find out the wishes of all the members of the social security system on such a controversial subject.

Hence, I respectfully and prayerfully ask that you have this communication printed in the Congressional Record as soon as possible and that it be made part of the public hearings to be held at a later date.

With all best wishes for country's progress,

Most sincerely yours,

CLIFFORD R. JOHNSON.

NEW APPROACH FOR MEDICARE

If either or both of the following new propositions are included in medicare legislation, no fairminded American need fear congressional approval.

1. Give members of the social security system the right to select a higher pension without medical benefits or a lower pension with medical benefits (the actuarial equivalent shall be the difference in the pensions).

2. Congressional medicare legislation must be subject to final ratification by a majority or a two-thirds vote of all social security members (similar to referendums for wheat farmers).

As the author of this simple new approach for quickly resolving the medicare debate, I urge prayerful consideration by both the Members of Congress and the general public on both sides so that the legislation logjam can be broken and America can march forward at a faster rate in this age of speed.

WASHINGTON, D.C., *May 19, 1965.*

Hon. HARRY FLOOD BYRD,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.:

Mr. Chairman, and all members of this committee, and other Members of U.S. Congress, must say, much has been learned from the hearings on H.R. 6675 in the past few days, however, the opposition is stronger, No, on "medicare"—No on "eldercare," and No on Long's proposal.

"Social Security," most unfair. So many not covered.

In the nursing profession, private duty nurses, practical or licensed practical, or graduate, licensed nurses, (that is, P.N., or L.P.H., or R.N.). They are covered while working for a hospital or nursing home, floor duty but not private duty in patients' home or hospital or nursing home or wherever patient resides. "Aides" and "babysitters" are not covered. So many other workers are not covered as testimony has been given by other witnesses.

The Kerr-Mills Act is definitely inadequate—and is not the answer to "the care of the sick." Each family should care for his own, likewise, each State the same. States Rights.

The "disability pay" now given through "social security" is not enough to meet the needs of a permanently disabled persons, to live on, especially a married person.

We, as good Americans, believe in freedom—but, if H.R. 6675 is passed and becomes a law—where are we? We do not need any further "socialism" or "socialized medicine."

Request the above statement be given deep consideration, in behalf of all people. Urge you not to pass H.R. 6675, because of its "socialistic" manner. Thank you.

The Lord's will be done—Amen.

Sincerely,

NELL MAY FERGUSON STEPHENS,
(Georgia) L.P. Nurse.

(Unpaid registered lobbyist.)

THE INDUSTRIAL COMMISSION OF OHIO,
Columbus, Ohio, May 18, 1965.

Hon. FRANK J. LAUSCHE,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LAUSCHE: As chairman of the Ohio Industrial Commission and on behalf of both the commission and the administrator of the bureau of workmen's compensation, I feel that we, as representatives of injured workers, employers, and the general public, should bring to your attention a matter of grave importance.

H.R. 6675, now before the Senate Finance Committee, contains section 303, which we strongly urge must be deleted from the bill. This provision would permit an individual to receive Federal disability benefits even if he was suffering a temporary disability and if he was unable to engage in substantial, gainful employment for 6 months or more. This liberal definition of total disability multiplies the already existing serious problem permitting duplication of benefit payments under the Federal social security system and the Ohio workmen's compensation program.

The ever-increasing attempts by the Federal Government through the social security system to invade what has been, since 1913, a State program has produced almost unbelievable results. Double payments not only discourage rehabilitation of injured workers but also increase costs to both the employer and the employee.

As an example, the result of duplicate payments of permanent total benefits to a worker with a wife and two children under 18 who is injured in the course of employment would be as follows under existing Ohio law and the proposed medicare-social security bill.

While working

Annual income	$6,000
Federal income tax (approximate)	500
Social security tax	174
Total tax	674
Total annual take home	5,326

After disablement (nontaxable)

Annual maximum social security benefits	$3,744
Annual workmen's compensation benefits	2,548
Total annual spendable income	6,292

Obviously a person who has almost $1,000 more to spend for not working has no incentive to return to work; and without a promise of financial gain, rehabilitation would, in most cases, be of no use.

The recognition of this serious problem was made by the House Committee on Ways and Means when it recommended a study to determine the exact nature and extent of the problem concerning the duplication of benefits. It would appear that the study should be made before the problem is magnified.

In summary, I am opposed to the present system of duplicating benefit payments, and certainly any enlargement of such as proposed by section 303 of H.R. 6675, because such a system:

1. Violates the basic concept that occupationally related disabilities are solely the cost of production to be paid through workmen's compensation, not social security;
2. Would bring efforts to limit workmen's compensation benefits to 6 months and thereby throw the burden of extended disability cases upon social security, resulting in a crippling of our State workmen's compensation system;
3. Will greatly increase the number of individuals receiving duplicate benefits totaling more than their net earnings before injury;
4. Will hamper efforts to rehabilitate injured employees;
5. Eliminates incentive, by way of premium rate modification, for employers to practice "safety" as in workmen's compensation because under social security all employers pay the same rate;

6. Will inevitably raise social security costs and bring demands that employers bear more than 50 percent of contributions; and
7. Would require employers, no longer bearing the entire expense of work injuries, to again be liable to common lawsuits.

Sincerely yours,

M. HOLLAND KRISE, *Chairman.*

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, AFL–CIO

My name is Melvin A. Glasser and I am director of the Social Security Department of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America, AFL–CIO. My office is located in the headquarters of the UAW, Solidarity House, 8000 East Jefferson Avenue, Detroit, Mich.

The UAW, on whose behalf I speak, is deeply appreciative of this opportunity to express our support of H.R. 6675. For a long time now, the almost 5 million UAW members and their dependents have added their voices and given their support to those who would seek to improve and strengthen the public programs and services to be made available to our retired citizens and to various other categories of persons whose basic needs are either not recognized at all or are still inadequately met through our current social insurance and public assistance systems.

The enactment of H.R. 6675 would not only strengthen and extend our time-tested social security system, it would also serve as a meaningful expression of the Nation's determination to recognize that economic security, access to means of preserving health, and a substantial measure of human dignity can be provided, under our system of government, to all Americans.

It is the conviction of the membership of the UAW and, we believe, the views of millions more, that America must remove the fear and financial burden arising from illness and must provide a system of basic income maintenance which in scope and adequacy is related to the current costs of maintaining a modest but a decent standard of living, and provides, as well, special assistance to those who face the problems of poverty, unemployment, widowhood, disability, and old age. H.R. 6675 is a vitally important effort to achieve this goal.

Through the collective bargaining activities of labor unions, a significant measure of economic security and independence has been achieved for some of the Nation's workers and their families. But for many active and retired workers, health care, pensions, and other benefits are either nonexistent or extremely limited. Thus, the UAW has long supported efforts to strengthen the public social security system.

In presenting our views and suggestions for modifications in this measure, I would first emphasize that we strongly support the bill's objectives but believe they can better be achieved if certain changes were made along the lines I shall indicate. I wish first, however, to stress the appropriateness and desirability of the application of social insurance to the provision of a number of basic health benefits for the aged. This is recognition not only of the feasibility of social insurance financing in the field of health care, but also of the fact that because a majority of the aged cannot now afford the level of premiums being charged by private health insurance plans for reasonably comprehensive coverage, and indeed those who need protection most cannot now afford to buy any, they require the assistance and protection of a public insurance program. It is axiomatic that the soundest insurance program provides for prepayment over as broad a group as possible so that risks are spread and costs made equitable.

The prepayment of hospital and certain other health care costs of the aged by social security contributions from the general population in their working years will mark a milestone in the history of social justice in this Nation. We are gratified as well that H.R. 6675 also recognizes that an adequate health insurance program must extend beyond institutional services. An important way of keeping people out of expensive hospital beds is to provide medical services to them when they are at home and when they are ambulatory.

On close review of the health insurance title of H.R. 6675, however, we find a number of major limitations which dilute the basic protection to be afforded the covered beneficiaries and which introduce undesirable and unnecessary limitations and restrictions. First let me deal with certain elements of the proposed basic hospital insurance program.

A. BASIC HOSPITAL INSURANCE PROGRAM

1. The use of a deductible feature in relation to both inpatient and outpatient hospital service

The introduction of a $40 deductible on inpatient services and a $20 deductible on outpatient diagnostic services is discriminatory, will have no influence as a deterrent to unnecessary hospitalization, and ought to be removed.

In support of this position I would point out the following:

(*a*) There is no evidence under either public or private insurance that an inpatient deductible either deters unnecessary hospitalization or reduces length of stay.

(*b*) The proposed inpatient deductible discriminates against the patient who requires hospital admission for a diagnostic workup and makes no distinction between patients with different lengths of stay.

(*c*) These deterrents are aimed at the very group in the population with high illness rates, and with lower economic resources to meet such charges.

(*d*) The proposed outpatient deductible could discourage the use of outpatient diagnostic facilities and redirect the provision of such services in a manner which will inflate the costs of providing this benefit.

In summary, we believe that reliance should be placed on hospital and medical review and control of the use of covered services and not on so-called economic deterrents which tend to be discriminatory, and imply that the patient's economic circumstances, rather than his health needs, may control his use of needed services.

2. The exclusion of in-hospital med l services in pathology, radiology, anesthesiology and physiatry

These services should be restored under the basic hospital plan. As pointed out by Senator Douglas, Senator Gruening, the American Hospital Association, the American Public Health Association and our own AFL–CIO, the exclusion of these services as covered hospital expenses is a wholly unjustified interference by the Federal Government with traditional hospital specialists relationships; will most seriously inflate costs; will confuse the public through a multibilling approach; and from an administrative point of view, will introduce arbitrary and completely impracticable costing procedures to the detriment of the hospitals and the patients.

3. Restriction on benefits in posthospital extended care facilities

(*a*) The requirement that admission to an extended care facility must be preceded by a period of hospitalization of at least 3 days is unfortunate. We believe it should be dropped, for it may well inflate hospital costs by having a great many people who do not require hospital care go in for 3 days in order to become eligible for the nursing home benefits. We recognize that this was an attempt to provide control on utilization of extended care facilities. Such control, however, must rest upon well defined relationships between the institutions and the physicians involved, on proper medical supervision of such facilities, and on implementation of well-known techniques of medical screening and review of patients.

(*b*) In view of the extreme importance of making the most economical and effective use of our health care facilities, the proposed maximum of 100 days of care in a nursing home, per spell of illness, should be increased to 180 days, and the minimum to 60 days. With unused hospital days substituted for nursing care days on a one for two basis, and the elimination of the 3 day prior hospital stay requirement, patients would be entitled to an annual maximum of 180 days in such facilities. This would constitute more realistic recognition of the needs of the elderly chronically ill and provide coverage more appropriate to their needs.

4. Use of private organizations to facilitate payment to providers of service

Notwithstanding the safeguards on the use of private organizations in the administration of the basic hospital plan, as enumerated in section 1816, we do not consider it appropriate nor in the public interest to delegate, under any public program, administrative authority to a private nongovernmental agency. Moreover, section 1816 would establish a serious conflict of interest within such a private organization, since it would be acting both as an agent of the Federal Government and at the same time representing the providers of service under the program.

Private agencies could, of course, receive payments from the Federal Government and disburse such payments to providers of service, in accordance with and under rules and procedures established by the Federal Government. But such financial functions, particularly in the field of health services, must be closely integrated with other vital administrative functions directed to the promulgation of high standards of care and services and to the application of safeguards against unnecessary utilization of services. H.R. 6675 clearly recognizes the advantages of combining the administration of financial and other management policies in a single agency. We strongly agree with this "single agency" concept. But such an agency, in our view, must not in any sense represent the providers of service, and must be in some direct relationship to Government and thus responsive to direct public control and public needs.

We therefore believe that it would be in the public interest, in that it would assure more effective responsiveness to public needs, and greater likelihood of development of quality care with sound utilization controls, for the Secretary to be required to utilize the official State Departments of Health as the administrative agents, in those States where:

(*a*) The State health department meets criteria and standards developed in advance by the Secretary—including representative public advisory boards.

(*b*) The State health department can demonstrate its willingness and capacity to carry out these administrative functions.

In the event the Secretary of Health, Education, and Welfare determines a State health department is not able or willing to be the administrative agent for this program, we believe the Secretary should be required to arrange for direct Federal operation of the program in that State through augmentation of the existing HEW organization in that area.

B. VOLUNTARY SUPPLEMENTARY PLAN

We also have several major concerns about the voluntary supplementary plan. The implementation of this plan, primarily related to physician services, is a vitally important extension of the basic plan. We do believe, however, that some changes are required if the program is to provide easy access to prompt, high-quality, and continuous ambulatory care, to discourage abuse and the rapid inflation of medical care costs.

1. Deductible and coinsurance features: We must, here as well, urge the elimination of the proposed $50 deductible and 20 percent coinsurance payments. It is known that total health care expenditures for the aged are twice as high, and hospital expenditures nearly three times as high, as they are for persons under 65 years. The Social Security Administration's 1963 survey of the aged also found that about four-fifths of aged beneficiaries are dependent on social security as their major source of income. Thus the imposition of these "dollar barriers" can be expected to represent a real hardship for those aged who have extensive and prolonged requirements for ambulatory care, and can be absolutely prohibitive for aged persons who suffer periods of institutional care. Moreover, such charges will discourage early and continuous care and supervision of the aged ill. They will also require costly and complicated administrative arrangements and controls which can only confuse patients and complicate doctor-patient relationships.

We would suggest to the committee that each aspect of this program be viewed against the objective of preserving health rather than paying for care in illness. This is a socially desirable goal and in the long run the most economical way to run such programs.

2. We urge the committee to reconsider the discrimination implicit in the special limitations and restrictions applied to this bill to patients in need of psychiatric care. We refer to the maximum annual benefit of $250 or 50 percent of charges, whichever is less, for out of hospital services, and the 180-day lifetime maximum on inpatient care.

This type of distinction between physical and mental illness is both unscientific and in our judgment, unworthy of a country that is attempting in so many important ways to recognize the rights and meet the needs of the mentally ill.

3. A third comment of a more general nature is the seeming lack of effective means to establish cost controls and encourage quality of care under the voluntary program. We commend the emphasis placed on hospital utilization review plans and the creation of a National Medical Review Committee, but we believe that similar utilization review programs should be established at the State and local levels in respect of nonhospitalized services.

We also believe the possible escalation of physicians' fees and the possible overservicing and rendering of unnecessary care, can be obviated, in large part, to the extent that this program seeks and obtains the highest level of cooperation and participation by the medical profession in implementing high standards of care and, where necessary, controlling abuses, under self-governing arrangements.

4. We would also urge that the program offer inducements to the group practice of medicine. Direct service group practice plans have clearly demonstrated that they can provide comprehensive high-quality care at lower unit costs, and make highly efficient use of limited resources. The UAW has had extensive and satisfying experience with prepaid group practice programs. We trust the administrative interpretations which will implement this legislation will recognize that the encouragement of this kind of organization of medical care is in the interest both of the recipients of the care and of the Government, which should be encouraging measures with the kind of built-in preventive medicine and cost controls that characterize these programs.

5. Our views on the administrative use of private carriers as fiscal agents under the voluntary program are similar to those expressed in respect to the hospital insurance plan; that is, we believe a State agency (or a regional Federal agency under HEW) must be given the administrative functions referred to in section 1842, assisted by strong State and if necessary local, advisory committees on which are represented both the providers and consumers of medical service.

C. PUBLIC ASSISTANCE AMENDMENTS RELATING TO HEALTH CARE

We support the proposal to increase Federal grants to the States to provide consolidated and liberalized programs of medical assistance and rehabilitation to the medically needy aged, public assistance recipients, and needy children and adults. This should make possible improvements in the scope and standards of service, particularly for those States which are in a position to provide full matching for increased Federal funds. These measures should also resolve in substantial administrative and program simplification.

We continue, however, to have strong reservations about perpetuating and extending a separate system of health services for the needy. All our experience indicates that this is generally inferior health care, no matter how much is spent on it. Many components of such health services are rendered without adequate regard to the quality of care, are often provided through inferior facilities, and are frequently unacceptable to the recipients because of the atmosphere of "welfare medicine."

The experience with the Kerr-Mills programs in many States has not been good for there is wide disparity among the States with relation to coverage, program content, eligibility provisions, and so forth—all affected by inadequate State financial support. It is regrettable that in the United States today the ability of a medically indigent elderly person to maintain his health, avoid serious crippling and even save his life, is directly related to the particular State in which he happens to live and the extent to which that State is able and willing to provide authorized care.

While there will always be need for special forms of health services for persons with special needs, the objective of the programs should be to integrate rather than to compartmentalize public health programs.

As a step in the desired direction we would propose that under the new title XIX the health programs for the medically indigent be organized, operated, and supervised by State health departments which are prepared to administer certain predetermined standards and which are already administering substantial health care programs. At the same time the State health departments could be authorized to delegate to the State welfare agencies the responsibility for determining eligibility for this medical care.

We are pleased to note the extent to which this bill attempts to overcome the present unsystematic and disparate eligibility provisions now applied to the various categorical programs of health care. We recommend, however, that States, in order to be eligible to receive these matching funds, agree to provide not only a basic core of medical and health benefits, but also that these basic benefits be uniformly defined as to scope and duration, for all of the States. The needs of a medically indigent person in Utah are not different from those of a similarly afflicted person in Michigan. It is our conviction that if Federal funds are to go into these programs, equal opportunity for obtaining good care

should be available regardless of the State of residence. We recognize that several of the so-called poorer States may find it exceedingly difficult to provide the necessary matching funds under such a uniform benefit formula. In such event we urge that consideration be given to modifying the Federal matching formula more effectively to aid the States at the low end of the income scale.

SOCIAL SECURITY AMENDMENTS (TITLE III OF H.R. 6675)

Of the many important changes proposed under title III, we would comment on two major features. These are: (1) benefit amounts, and (2) the creditable earnings base. These, in our judgment, need additional strengthening to maintain the OASDI system on a current basis as the major source of income security for the majority of retired workers.

The 7-percent increase in benefits (with a minimum of a $4-monthly increase for those retiring at 65 years) and the relating of family benefits to workers' earnings at every bracket in the benefit table are improvements which will be welcomed by all. In our opinion, however, the proposed increases in benefit amounts are disappointingly low, as is the proposed new maximum annual earnings base of $6,600 beginning in 1971. Indeed, the whole level of benefits continues to be related to the low level that was initiated in the beginning of the system and is not related to present wages and standards of living. The proposed increases cannot really be accepted as making up cost-of-living increases since the 1958 benefit increases. And certainly the proposed earnings base of $6,600 will not substantially retain the wage-related character of the program.

The recommendations of the Social Security Advisory Council, as you know, recommended an average increase of 15 percent in benefit amounts, and a maximum earnings base of $7,200, effective 1968. Even this earnings base of $7,200 would probably not cover more than 80 percent of total covered earnings in 1968—far below the 95-percent level of taxable total covered earnings contemplated in 1935 when the Social Security Act was written. Substantial increases beyond those contemplated in H.R. 6675 are needed in relation to benefit amounts and the earnings base if we are to provide adequate resources and protection for our retired citizens, commensurate with this Nation's productivity and sense of social justice.

From these remarks, Mr. Chairman, I hope you and the members of the committee will draw the conclusion that the UAW, its members and their families, are solidly supporting this bill. This legislation is a historic landmark in the long efforts to achieve a major social objective in American life—a social insurance system to help protect all workers and their families from some of the major hazards of our industrial society. We note, with pride and with satisfaction that the Congress has come this far in its recognition that the health of all Americans is indeed a precious commodity and that there is governmental responsibility in assisting Americans in preserving and maintaining that health.

We have referred to certain problems in this proposed legislation, which we hope will receive your earnest and sympathetic attention. The modifications we propose we believe will make an even better measure of the bill before you. Your speedy and favorable support of H.R. 6675 will earn you the gratitude of the Nation.

CANFIELD, OHIO, *May 10, 1965.*

Senator FRANK J. LAUSCHE,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR LAUSCHE: Dr. John McDonough and I appreciate the opportunity of having talked with you when we were in Washington, Thursday, May 6. You asked me then to send you information regarding H.R. 6675 with particular reference to the proposed Senate amendment to include anesthesiologists, pathologists, radiologists, and physical medicine into the medicare bill. This I am happy to furnish.

As you know, the bill as passed by the House excludes these specialties from part A (the King-Anderson portion). The services of these specialties would be covered, however, under part B, the extended benefits portion, or the voluntary Byrnes provision of H.R. 6675. We are told there will be an attempt on the floor of the Senate to amend the bill to include these specialties under the King-Anderson part, and this, most doctors of medicine would oppose because it would make these doctors of medicine employees of the hospital. We feel that it is

extremely important that these men be permitted to continue to practice and render a fee for their services separate from the room-and-board type of charge submitted by the hospital. I was happy to learn that you favor our point of view and I hope that you will be able to help us in this regard.

The second point I'd like to make, Senator Lausche, is that most doctors, at least in Ohio do not wish to be included under social security. Of course, there are some doctors who would like to be covered; for the most part, these are the men close to retirement. In the past the Senate has felt that doctors would be included if they wished to be. May I make a plea at this time that I for one and many of the men whom I represent do not wish to be included.

Again, sir, thank you for your time in talking with us about the medicare bill. I have been most pleased with your stand in the past and I have been impressed with your overall voting record. It is clear to me at least that Senator Lausche is not going to rubberstamp everything that comes from the White House. This is an encouraging note in an otherwise rather bleak situation. If I can be of any further help regarding this bill, I shall be most happy to furnish any information upon your request.

Sincerely,

JACK SCHREIBER, M.D.

(Whereupon, at 11:40 a.m., the committee adjourned, subject to call of the Chair.)

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