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SOCIAL SECURITY AMENDMENTS OF 1970

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

H.R. 17550

AN ACT TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE INCREASES IN BENEFITS, TO IMPROVE COMPUTATION METHODS, AND TO RAISE THE EARNINGS BASE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS WITH EMPHASIS UPON IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF SUCH PROGRAMS, AND FOR OTHER PURPOSES

PART 2 OF 3 PARTS

SEPTEMBER 14, 15, 16, 17, AND 21, 1970

ADMINISTRATION AND PUBLIC WITNESSES

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SOCIAL SECURITY AMENDMENTS OF 1970

MONDAY, SEPTEMBER 14, 1970

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

The committee met, pursuant to notice, at 10 a.m., in room 221, New Senate Office Building, Senator Russell Long (chairman) presiding,

President: Senators Long, Anderson, Talmadge, and Williams of Delaware.

The CHAIRMAN. This hearing will now be in order.

The Committee on Finance today begins receiving testimony from public witnesses on H.R. 17550, the Social Security Amendments of 1970.

The committee had the benefit of the administration testimony on this measure on June 17 and July 14 and 15. We heard from the administration at that time in order to expedite the business of the committee and the Senate while the Department of Health, Education, and Welfare was working on revisions to the welfare expansion bill on which we have just concluded public hearings.

H.R. 17550 provides for a 5-percent, across-the-board social security benefit increase effective January 1970. It also modifies the cash benefit social security programs in several respects. A major provision requiring careful discussion and consideration authorizes the Secretary of Health, Education, and Welfare to increase social security benefits whenever he determines that the cost of living has increased by 3 percent. A companion provision calls for automatic increases in the amount of wages, taxed every 2 years and thus, higher social security tax, based on the Secretary's determination of the extent as to which the average wages have risen since 1971.

The committee will want to look most carefully at this provision since it may involve a delegation of the taxing power vested in Congress under the Constitution. The House bill also increases immediately medicare taxes by a staggering 77 percent over the next 25 years, in order to raise the $200 billion plus that will be needed to make up the projected 25-year deficit in the program.

This proposed increase would be on top of the medicare tax, increase approved by Congress in 1967. A medicare deficit of this magnitude should not have occurred if the program had been operated on an aggressive hard-headed, business-like basis, and if Congress had been asked promptly to close the gaps in that program which now loom so large.

The Finance Committee has held a series of legislative oversight hearings over the last year to examine the problems in the medicare-medicaid programs and we have published a detailed report including

recommendations for strengthening the two programs. Some of these recommendations have already been incorporated by the House in their bill which we are considering today.

We will, during the course of these hearings and in subsequent considerations be looking for ways of controlling excessive costs under medicare and medicaid. If we are successful in our efforts then hopefully we may not need to increase medicare taxes as sharply as the House bill proposes. This morning we will be pleased to have as our first witness a gentleman who appeared before us many times on behalf of the Social Security Administration. In view of the fact that the Senate is in session at this moment, and that a quorum call is going on in the Senate, because it had to quit for lack of a quorum on Friday, I am going to move that this committee stand in recess for the next 5 minutes at which time we will then proceed to hear from the witness who we had anticipated hearing from, Mr. Robert J. Myers.

Thank you.

(Short recess.)

The CHAIRMAN. Mr. Myers, the testimony we expect to take here this morning is, in the judgment of the chairman of this committee, exceedingly important, and you are a man who is as well qualified as anyone to tell us why the program that we have is costing so much money, and what the prospects are for trying to keep these programs within their estimates for the future. Ordinarily, we don't conduct committee hearings while the Senate is in session. But in view of the late day in the session, and the desire of Congress to act on this bill before Congress adjourns we are conducting this hearing while the Senate is in session.

There is another vote that will be taking place in the Senate within just a few moments and, therefore, I believe it would be best to wait until we have at least the possibility of a quorum present here in this committee and for that reason I am going to wait until 11 o'clock to call Mr. Myers. I would like to have Senators who are concerned about the cost of social security and public welfare here, Mr. Myers, and about the only way that I know to improve the possibility that they will is to postpone this hearing for a few more minutes until the Senate is through voting on the amendments that are presently pending.

(Short recess.)

The CHAIRMAN. The Chair will now call this meeting to order and call Mr. Robert Myers as a witness.

Mr. Myers, we are pleased to have you here today and we appreciate your making yourself available to the committee to discuss the costs in this bill. Will you proceed in your own way, sir?

STATEMENT OF ROBERT J. MYERS, FORMER CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

Mr. MYERS. Thank you, Mr. Chairman.

As you know, I was Chief Actuary of the Social Security Administration for a number of years, and I am now an independent consulting actuary and also, beginning in September, professor of actuarial science at Temple University.

Of course, the testimony I am giving is on my own behalf and not on behalf of Temple University.

I am appearing today primarily to make myself available to you for any questions about the cost estimates, since I was responsible for them up through the passage of the bill in the House. Also, I want to point out a few provisions in the bill and make a few suggestions for changes in the program that I think will improve its administration and public understanding and at the same time provide better benefit protection.

On the whole, I very strongly favor and support the bill that the administration introduced last fall, and when I say favor the bill, I mean that I believe that the bill, as presented, was just right. It was neither too much nor too little in terms of either benefit expansion or costs. This is unlike some people who say they support a proposal, meaning they are in favor of at least that much and are really in favor of much more.

When the bill was presented by the administration last fall it was in very close actuarial balance. The action that the Congress took last December of providing a 15-percent benefit increase across the board was soundly financed, but it did use up the portion of the actuarial surplus that was going to be available to finance the other benefit proposals in the administration bill.

Accordingly, I think there is some question of whether all the benefits proposed in the bill now should be enacted.

In other words, when you have a certain amount of money and you go to two stores, then if you spend more at the first store than you planned, you should reexamine whether you ought to cut down your spending at the second store.

In effect, what has been done is to increase the cost of the program by adopting all the benefit liberalizations proposed by the administration last fall and, as a result, the financing has had to be increased.

The CHAIRMAN. Mr. Myers, I would appreciate it if you would take time to make it clear to us what you are thinking.

As I understand it, you are saying that you think the bill that originally came before the House was a package that you would be strongly in favor of. But, in view of the fact that there have been a number of things added to it, if I understand you, you think we ought to reconsider some of the benefits. Is that right or wrong?

Mr. MYERS. Yes; that is correct, Mr. Chairman.

The CHAIRMAN. I take it then that you feel looking at the bill responsibly, from a cost point of view, that we might be well advised to reconsider some of the benefits in this bill.

Mr. MYERS. Yes; Mr. Chairman, that was my viewpoint.

The CHAIRMAN. Yes.

Mr. MYERS. And, in particular, in my testimony, I point out that the proposal to give a 100-percent widow's benefit at age 65 is very meritorious in many ways, but it does create certain inequities and anomalies, such as the widow in some instances receiving more than her husband would have received if he had survived her.

The CHAIRMAN. What is that going to mean if we pass the equal rights amendment?

Mr. MYERS. Well, it would seem to me that——

The CHAIRMAN. It would mean both of them would get it at 62; doesn't it?

Mr. MYERS. It would seem to me this is not an equal right in this particular provision because the widow gets a 100-percent benefit, and the man might only get an 80-percent benefit even though he has been the worker and the contributor.

The CHAIRMAN. What some of us object to in the equal rights amendment, as I understand it, is that in those cases where you would have to pay more to a woman than you would pay to a man, it would require you to pay the man more to bring hem up to what the woman gets, because if you didn't do that people might prefer to hire men because they could hire them cheaper.

Mr. MYERS. That is a possibility, Mr. Chairman. I think there is a partial solution for this provision, because, as you know, the widow gets a full benefit at age 65, and if she takes it earlier she gets a reduced benefit. However, there is no account taken of the fact if she had been drawing a wife's benefit from age 62 on; thus, the reduction should perhaps apply from when she first drew a wife's benefit, rather than merely when she first drew a widow's benefit.

I also suggest in my testimony four minor changes that I think would improve the benefit protection and would simplify the administration; namely, that family benefits for future claimants should be increased in the same proportion as for those on the roll. Now, there is a very considerable anomaly when you increase benefits; some people who come on the roll the next month get less than those in similar circumstances who were on at the time the benefit increase was given. This doesn't seem fair, and it has created some problems.

Another thing I suggest is that under present law a young worker who is disabled after the earnings base has been changed and who has been a high-paid worker might get a much larger benefit than somebody who has been in the program for 30 years at maximum earnings all along. This seems unfair to the long-time contributor as against a younger person who has just come into the system.

The third thing I suggest is changing the lifetime reserve provision in the hospital insurance program so that it is not on an elective basis, but rather everybody gets 150 days of hospital benefits in a spell of illness, with the coinsurance provisions that apply now. As it is now, many people have great difficulty knowing whether to elect these reserve days or whether to save them for some later time.

The fourth thing I suggest is to eliminate the 100-visit maximum for home health services under part B. I think this is just a complication in administering the program, and it affects so very few people that it doesn't seem worth retaining, especially since there is no maximum on the number of physician visits.

Finally, I point out, without taking a position for or against it, that the proposal to limit increases in reasonable charges for physicians will eventually lead to a flat fee schedule, as opposed to the present basis, which is reasonable and customary charges. I am not saying I am opposed to a flat fee schedule for reimbursement of physicians, but what I do say is that I think many people have not realized that this is the inevitable mathematical result of this provision in the House bill.

(Mr. Myers' prepared statement follows. Hearing continues on p. 348.)

STATEMENT OF ROBERT J. MYERS

SUMMARY

1. Principal purpose of testimony is to make myself available to answer question on actuarial cost estimates for pending Bill.

2. From an overall viewpoint, the original Administration proposal was excellent and well-rounded, both as to benefit changes and the necessary financing.

3. All of the available actuarial surplus was used up by the 15% benefit increase enacted in December 1969. Therefore, there is a question whether other benefit proposals should be enacted since to do so means upsetting the financing proposals and results in an ultimate employer-employee tax rate for the cash benefits program of 11%, as compared with the present 10%, which had been maintained in the original proposal.

4. The proposal to increase widows' benefits is attractive from some standpoints but has disadvantages by favoring widows as against women workers and by producing significantly larger benefits for a widow in some cases than are available for the primary worker if he should survive his wife.

5. Four suggestions are made for minor but significant changes to increase benefit protection and to simplify administration and public understanding—namely, (a) increasing family benefits for future claimants so that they are on the same basis as for present beneficiaries, instead of being lower; (b) eliminating the inequity that younger workers receive much larger disability and survivor benefits in maximum or near-maximum earnings cases than do older, long-time contributors; (c) change the lifetime reserve provision in the Hospital Insurance program so that such days are available for each spell of illness rather than involving the undesirable, difficult elective situations under present law; and (d) eliminate the 100-visit maximum for home health services under the Supplementary Medical Insurance program, which rarely has an effect and complicates administration.

6. Discussion of how the change in the method of determining reasonable charges for physicians will eventually lead to a flat fee schedule for each procedure for a particular locality.

Mr. Chairman and Members of the Committee, my name is Robert J. Myers, and I am an independent consulting actuary and also, beginning in September, Professor of Actuarial Science at Temple University. As you know, until recently I was Chief Actuary of the Social Security Administration, a position which I had held since 1947.

I am appearing today primarily to make myself available to your Committee to answer any questions about the actuarial cost estimates for the pending Bill, since I had had the responsibility therefor up through the time that the House of Representatives enacted the legislation.

I should also like to take this opportunity to give my views on the general desirability of the pending legislation and to point out several relatively minor, although significant, points in the Bill and in the present Act where I believe that changes are needed to improve equity or to simplify public understanding.

First, let me start with the proposal made by President Nixon last fall. In my opinion, this was an excellent, well-rounded proposal, combining both necessary and desirable benefit changes with adequate financing. Such financing involved tax rates that would not exceed those in present law. A substantial part of the liberalizations in the cash-benefits program were to have been achieved through the then-existing estimated acturial surplus. The action of the Congress in December 1969 in legislating a 15% benefit increase, as compared with the 10% increase recommended by the President, used up the entire actuarial surplus, part of which was to have been used for other benefit liberalizations. I support completely this legislative proposal of the President.

· might point out that when I speak of support of a particular proposal, I mean full support in the sense that I believe that anything significantly less would not be enough, and simultaneously, that significant further liberalization would be undesirable. Some people use "support" in the sense that they favor at least as much liberalization as contained in the proposal but, actually, much more. In my opinion, this is not really "support".

It seems to me that the prudent course of action when one spends more money than anticipated in the first store which is visited is to spend less in the next store. Such action, however, was not taken and all of the benefit liberalizations proposed by the Administration have been included in the pending Bill. This

can mean only that additional financing would have to be provided for the cash-benefits program. The Bill has properly done this by providing for an ultimate combined employer-employee tax rate of 11%, beginning in 1980.

This is the first time that the 10% ceiling has been breached. Although I do not believe that there is anything sacred about such a ceiling, there is some question as to whether all the major cash benefit changes are really necessary, even though individually they are attractive.

For example, the increase in widow's benefits claimed first at age 65 to 100% of the primary benefit has certain obvious appeal. However, it should be pointed out that, under present law, the average widow's benefit is at the same level as the average benefit for a woman worker (each at about $102 per month). Under the proposal, the average widow's benefit would be significantly higher than the average benefit for a woman worker. Accordingly, a woman worker could well complain about the inequity of the situation as against her non-working married sister; the latter will receive a higher benefit because she gets the full primary benefit of a male worker, who generally has a higher wage level than a female worker.

There is still another anomaly that arises when widow's benefits are increased in this manner. Consider a man retiring at age 62 with a wife the same age. If his primary insurance amount is $200, the total monthly benefit for his wife and himself will be $235. Then, if he dies after 3 years on the roll, the widow gets $200 per month, or 85% of the amount paid when both were alive. On the other hand, if the wife dies first, the worker's benefit is $160, or only 68% of the total family benefit and $40 (or 20%) *less* than the non-working widow's benefit under similar circumstances!

Now, let me turn to several small, but significant changes which I think should be made in the interest of equity and of understanding and administering the program.

First, in providing a 5% benefit increase for those on the roll in December 1970, the family maximum benefit limitation is waived, so that all beneficiaries should receive the full 5%. For future beneficiaries, the 5% increase applies to the primary benefit, but in most instances no change is made in the family maximum provision. This creates an inequitable situation for similar families who come on the benefit roll just before and just after the effective date, since the latter receive 5% lower benefits. I suggest that, in equity, the maximum family benefits shown in the benefit table should be increased by 5% for all average monthly wages up to $650 (except where the maximum of 1½ times the primary benefit already applies) and that there be appropriate grading in between average monthly wages of $650 and the maximum in the Bill for an average monthly wage of $750.

In the same manner, the automatic-adjustment provisions as they relate to the benefit table should be modified so that, as cost-of-living increases are given, these will affect the maximum family benefit in the same manner as they affect the primary benefit. The objection may be raised against this proposal that the formula underlying the maximum family benefit at the lower end of the scale is based on 80% of average monthly wage and that, accordingly, this relationship will eventually rise to 100% or more of average wage.

This objection is not valid, however, because the procedure for computing benefits over the long range is such that the derived average wage is based on a long period, but it is really only a national average which is used to derive meaningful benefits when related to final wages. In other words, what the Congress has done in the past two decades by *ad hoc* adjustments and what the automatic adjustment procedure in the Bill would do in the future is to use the career-average method in such a manner that it is really changed to a final-average method through the across-the-board benefit increase method involved. This proposal would increase the level-cost of the OASDI program by about .02% of taxable payroll.

My second suggestion relates to the inequity in treatment as between workers who have been covered by the program for long periods as against young new entrants, when the maximum taxable and creditable earnings base is changed. Oddly enough, the young new entrant who has contributed for only a short time receives substantially larger benefit protection in the event of death or disability than does the middle-aged or older worker who has been contributing to the system for many years.

Specifically, under the pending Bill, a worker who has been covered at the maximum earnings ever since the program began in 1937 and who becomes disabled at the end of 1972 at age 61 or less will have a primary benefit of $213 per month. On the other hand, a worker with maximum earnings who similarly becomes disabled at the end of 1972 at age 23, but who was covered for 1971–72, would have a primary benefit of $283, or $70 more than the older worker who had been contributing for over 35 years. This is despite the fact that the young worker contributed in OASDI employee taxes only $756, as against the $4,325 for the older worker! Similar inequitable situations arise in survivor cases.

I suggest that the way to eliminate the foregoing inequity under which higher benefits are possible for short-term participants as for long-term ones with the same earnings level is to provide that, for death or disability in a particular year, the primary insurance amount shall not be larger than that which is possible for a worker attaining age 62 in that year (except that this provision would not result in a lower PIA than that payable on an average monthly wage of $650, since otherwise benefit protection would be reduced for some present participants). This reduction in benefits for young workers with very high earnings is not inequitable to them, since the benefits payable in these cases will greatly exceed their contributions, and the benefit amounts involved will still be quite sizable.

My third suggestion is to change the lifetime-reserve days provision in the Hospital Insurance program so that, for each spell of illness, the entire 60 days will be available (with the present coinsurance provision). This will provide slightly better benefit protection for catastrophic long-term hospitalization. More importantly, however, this change will greatly simplify administration and public understanding, because there will no longer be the undesirable and difficult situation of the beneficiary having to decide whether or not to use lifetime-reserve days now or to save them for the future when they might be more valuable. The increase in cost for this proposal when expressed in terms of a percentage of taxable payroll is negligible.

The fourth suggestion is in connection with the limitation of 100 home health visits per year under the Supplementary Medical Insurance program. Such a limitation is present under the Hospital Insurance program and is desirable because no cost-sharing on the part of the beneficiary is involved. Under SMI, there is no limitation, for example, on the number of physician visits per year, and there seems no logical reason to have such a limit on home health visits. Such a limit complicates administration and public understanding. Moreover, this limit affects only relatively few persons (an estimated 3,000 individuals each year out of the approximately 10 million persons covered).

The few who are affected by this maximum have serious financial consequences that should be eased by its elimination. The maximum does not really serve as a control of utilization since it applies in so few cases. I estimate that if this change were made, the monthly premium rate payable by the enrollee would be affected costwise by only about ¼ to ½ cent per month, an amount which is easily absorbed in the margin of contingency that had been included in the premium rate.

There is one other point in the pending Bill which I think should be more clearly called to the attention of all persons concerned—namely, the fact that the change involved in determining reasonable charges of physicians will eventually lead to a flat fee schedule for each procedure for a particular locality. This is in contrast with the situation under present law, under which the vast majority of physician charges are reimbursed on a customary-charges basis.

As you know, under present law, the basis for reimbursement of physician fees is the customary fee of the physician, unless this exceeds the prevailing-charge limit in the locality. Under present law, generally only about 17% of the cases involve the prevailing-charge limit instead of the customary-charge amount; under the Bill, this proportion would be increased to 25% for fiscal year 1971. However, in later years the prevailing-charge screen would be increased by an economic index, rather than by the general movement of customary charges in the locality. It seems certain that this economic index will move upward much more slowly than customary charges generally. Accordingly, as time goes by, the proportion of physician fees which are reimbursed on the prevailing-charges limit will rise from the initial 25% until ultimately becoming 100%. At that time, all reimbursement of physician fees will be at a fixed amount for each procedure each year in the given locality. Personally, I see nothing wrong with this procedure just as long as all parties involved fully realize what is being done.

The CHAIRMAN. Mr. Myers, you explained to us when you testified previously in February why the cost of medicare greatly exceeded all the estimates, and I think that you said that it was, a matter of increased utilization and also inflation in prices. There was much greater utilization than you anticipated and also much greater price increases than you anticipated, is that correct?

Mr. MYERS. That is correct, Mr. Chairman.

The CHAIRMAN. Now those two caused this program to exceed the costs by almost a hundred percent, is that right?

Mr. MYERS. By about a hundred percent.

The CHAIRMAN. If you are advising us how to get the genie back into the bottle what would your advice in general terms be to us? How can we get what we were hoping to get for the money?

Mr. MYERS. Well——

The CHAIRMAN. If you have some doubt about that let me ask you what your reaction is to the recommendations of our staff, based on the study they made of this matter.

Mr. MYERS. I think that I would concur with the vast majority of the recommendations made by your staff when they looked into this problem. I don't think there is any way possible to get the costs decreased to the level of what the original estimates were, because hospital costs have just risen so much there is no way of legislating them downward. The main thing to do is to try to control these costs in the future. I think the bill has made many good changes in this direction, and we can only hope that, on examination of the future experience, they will have had the desired effect. I think this is a problem that has to be continually worked on and studied and given close supervision the way your staff has done.

The CHAIRMAN. Yes.

Now, before you left the Government you wrote an article to the effect that there were two different philosophies in the Department of Health, Education, and Welfare; one was the expansionist philosophy, and the other was a philosophy that you adopted yourself. What would you call your philosophy as compared to expansionist?

Mr. MYERS. I used the term "moderate," Mr. Chairman.

The CHAIRMAN. Moderate.

And your thought of the moderate philosophy, I believe, was that you would try to provide for a person's essential needs, and not try to provide for all their needs. That was about it, if I understand it correctly.

Mr. MYERS. Yes; that was about it, or to use another term the "floor of protecrion" concept upon which economic floor people could build and which would take care of the vast majority of the people without their needing supplementary assistance. I also think it is the philosophy that, on the whole, the Congress has adopted, and has continued to put into practice over the 30 years of operation of the program, and I want to see that continued.

The CHAIRMAN. I am just looking at the conclusion of your article which was placed in the record. I thought enough of it to pass it around and suggest to some people that they read it, because I thought it raised some interesting questions. In considerable measure, I found myself in agreement with the answers that you provided. Here is what you said:

In summary then, one may well raise the question "How much economic security should be provided through the Government?" Should social security provide only a basic floor of protection, upon which individuals and, in part, their employers should build, with public assistance for the small minority whose basic needs are still not provided for—as the moderates believe?

Why should Government supply complete economic security to the aged, the disabled, and the survivors of deceased workers so as to replace virtually the full wage loss—as some expansionists advocate? If so, what are the implications in other areas such as medical care for the total population and even the ownership and management of industry and commerce?

If all should be guaranteed or provided, the highest possible medical care by the Government, how about guarantees or provisions so that none shall have incomes substantially below the average, or that none shall have diets that are not the highest nutritional quality, regardless of whether they could afford to—and would wish to—do otherwise?

There is a basic, important question here for America to decide. There is a choice to be made, and the citizens should be given all the facts on both sides, so that they can make a wise decision.

As a postscript, I might add that the social security proposals made recently by President Nixon, and now under consideration by Congress, fully meet the criteria of the moderate philosophy.

Would that be correct, based upon what you know to be before the committee now?

Mr. MYERS. Yes, Mr. Chairman.

The CHAIRMAN. At the hearings of the House Ways and Means Committee, several proposals were put forth that were definitely along expansionist lines.

Now, what is your reaction to the proposal that was recently introduced that we provide health care by a Government program to apply at all ages. Are you familiar with that?

Mr. MYERS. Yes, Mr. Chairman. There are several bills that have been introduced by distinguished Senators and Representatives along these lines.

In my opinion, these are not desirable proposals because I think that the health needs of the vast majority of the people under 65 are being taken care of through private means such as Blue Cross and Blue Shield, insurance companies, employer-sponsored plans, and so forth.

I think that there can be certain changes in medicare to make the protection more equitable and better. Perhaps certain types of social security beneficiaries should be under medicare and so forth, but I believe very strongly that a universal program for everybody in the country, thus replacing the vast network of private health insurance that has been built up already, would be undesirable.

The CHAIRMAN. Well, we will not permit a citizen to deduct medical expenses if those medical expenses are less than 3 percent of his annual income. If we don't think it is sufficiently serious to permit the individual to deduct it for tax purposes why do you think or why would you think that we should propose to pay that for citizens under a compulsory insurance program?

Mr. MYERS. I think your point has great logic. It seems to me that, although I am by no means an expert on taxation, if the taxation theory is that people can readily bear up to 3 percent of their income for meeting medical expenses before tax deduction for the vast majority of people, then the existing system is working out very satisfactorily.

The CHAIRMAN. In view of the fact that all prior medicare estimates have been too low, is it possible that the estimates for the present proposal for health insurance for eveybody might also be too low?

Mr. MYERS. This is quite possible. I have examined some of these cost estimates. A few of them I had made, when the sponsor of the legislation had asked the Department of Health, Education, and Welfare to make the estimate. Others, I think, were definitely too low, but again it is possible the estimates that I made are too low, even for these proposals. I always try to make the best estimates I can and because of being too low in the past, I didn't suddenly swing over and say, "I am going to put a real big margin of safety in it so that this time I will be right." Each time I have approached the cost estimate afresh and said "I will view the circumstances now present, make future assumptions as best I can, and here is the estimate."

The CHAIRMAN. Do you have any reaction to the present family assistance plan which we are considering, that would double the number of people on welfare? Some were suggesting that before we increase the number of people being benefitted by public welfare assistance by 10 million people we ought to first experiment with the plan and see how it worked out. What is your reaction to that?

Mr. MYERS. The only real reaction I have on the family assistance plan, since I haven't gone into it very deeply, is in regard to the cost aspects.

As you may know, I prepared a separate, independent cost estimate for the proposal as it was considered by the House of Representatives. My estimate was, as I recall, some $1 billion per year higher than the official estimates of it are somewhat on the low side.

The CHAIRMAN. What were the factors that caused you to think that it would cost a billion dollars more than the departmental estimate.

Mr. MYERS. The people in the Department who had the responsibility for the cost estimate and I approached the problem from an entirely different viewpoint. I would say the big difference is that I assumed that people would utilize the plan by perhaps changing certain economic patterns to fit the provisions of the plan—just as in the social security program with the retirement test, many people adjust their earnings so as to maximize their total income.

The people in the Department who made the estimates assumed that the situation would be static and that people would not adjust to the plan. When I say "adjust," I don't mean anything illegal, but it is just that man is an economic creature and, if conditions are in a certain manner, he will adjust his own living and his own earning capacity perhaps to fit in with the legal provisions that exist, whether it be taxation or benefit plans.

The CHAIRMAN. Well, looking at a situation where a person could quit work and make almost as much as he would make if he was working, would you be inclined to think that quite a few people might find it desirable just to quit work?

Mr. MYERS. Yes, I certainly would think so. Some people would and some won't, but certainly a significant number would. This is, as I indicated, one of the reasons for the differences between my cost estimate and the official one made by the Department.

The CHAIRMAN. Thank you very much, Mr. Myers.

Mr. MYERS. Thank you very much, Mr. Chairman.

The CHAIRMAN. Senator Williams will be here in just one moment and I will let him ask some questions. Thank you very much.

We will call the committee back to order as soon as we can make this next vote. Thank you.

Mr. MYERS. Thank you, Mr. Chairman.

Senator WILLIAMS (presiding). The next witness will be Dr. Paul Leithart, president of the Association of American Physicians and Surgeons.

You may proceed.

STATEMENT OF DR. PAUL W. LEITHART, PRESIDENT, ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC.; ACCOMPANIED BY DR. WALTER W. SACKETT AND FRANK K. WOOLLEY, EXECUTIVE DIRECTOR OF THE ASSOCIATION

Dr. LEITHART. Thank you, Senator. I am Dr. Paul Leithart, president of the Association of American Physicians & Surgeons. Our organization is a nationwide association of doctors with membership in over 1,300 counties, in all of the 50 States, and Puerto Rico, and in the District of Columbia. The members seek through this association to protect the responsibility, independence, and freedom of doctors and patients.

We appreciate this opportunity to present our views.

We are deeply concerned about the trend of this legislation which extends medicare and revises medicaid. Our concern deepens as we study the report of your staff in which the failures of these programs are admitted. We are not reassured by the admissions in a recent HEW task force report on medicaid. Also, statements of the administration advocating deeper and deeper government intervention into medicine disturbs us. Also, apparently well intentioned, but misguided, efforts to perpetuate these admitted failures—with doctors policing other doctors in an attempt to make an inherently unsound approach work need careful examination in the light of fundamental principles.

Government intervention in medicine is fraught with profound moral, economic, and political consequences which are presently only gradually being explored and understood. These consequences are widely misunderstood by the profession and public alike, as being accidental, transitory, easily remedied or due perhaps to the weakness of a particular approach, employee or administration. This is not true. The strains and stresses, the inadequacies and dissatisfactions which the profession and public experience are implicit in the nature of government intervention itself.

MEDICARE AND MEDICAID ARE IN TROUBLE

Your staff reported in February that after 5 years of medicare and medicaid these programs are in serious financial trouble. The two programs are also adversely affecting health care costs and financing for the general population.

We thank you and your staff for exposing the situation. These programs are in such difficulty that about 1 year after medicare, taxes were increased 25 percent. Now it is proposed to further increase taxes by many billions of dollars. Without these increased taxes HEW admits that funds will be exhausted by 1973.

HEW SPENDING EXCEEDS ALL CORPORATE PROFITS; GNP OF CANADA, AND SO FORTH

However, the situation is even more grave than Government reports disclose. For example, the entire Department of Health, Education, and Welfare is now spending at an annual rate of over $58 billion per year. This is more than all the profits after taxes of all the corporations of the United States—$58 billion against $48.5 billion of profits after taxes. It is the most expensive nonwar operation known—exceeding the $57 billion gross national product of the entire 20 million people of Canada. Yet, H.R. 17550 proposes that HEW spend more.

Your staff states that:

(1) Medicare and medicaid programs may be greatly extended to others.

(2) They can be made to work more efficiently and economically by tightening Government controls and administration.

(3) The key to making the present system workable and acceptable is the physician and his medical society.

(4) Prompt action is necessary by organized medicine to police and discipline itself concerning care and charges to avoid control procedures which may be arbitrary, rigid and insensitive.

ACTION NEEDED

We agree that prompt action is necessary, but not by doctors. Prompt action should be taken by Government to stop this reckless spending and waste. The actual crisis faced by the United States results from the lack of discipline, control and restraint by the Central Government.

The key to making the present system workable and acceptable is not the physician and his medical society but rather the elimination of the excessive spending and interference generated by these programs.

POLITICIAN VERSUS MEDICAL CONSIDERATIONS

The fact is that political medicine is bad medicine—not because politics is bad and medicine is good, but because the two do not mix. Wherever medicine has been dominated by politics, it has been bad. The record speaks for itself. Political promises have been made that Government will give more benefits than are available with little or no cost, without interference in, or control of the practice of private medicine, and with payment of usual and customary fees, all will be equal, all will get the best. Hard choices will no longer be the individual responsibility of the patient. He will no longer have to choose between using earnings for medical care needs and others such as housing, and so forth, and even luxuries. These promises have proven to be unrealistic and the reports of your staff for the most part so indicate. The reasons are clear.

When the individual was relieved of responsibility for exchanging something of value for the medical services sought, no responsibility was felt for restraining wishes. As a result, artificial demands for doctor and hospital care increased, forcing costs up to Government and private seekers of services alike. Taxes increased. Government further encroached upon private practice. Physicians and hospitals were re-

quired to obtain more clerical help to fill out Government forms. Doctors were forced to divert time from the care of patients to supervise reporting and often had to make lengthy justifications to remotely involved utilization review committees and ordinary government clerks as to why they did what they thought was necessary at the time of decision. Expensive, cuumbersome, and inefficient Government administrative procedures for control of use and cost and for research in improving medical care, diverted doctors and other scarce medical personnel from patient care.

Dr. SACKETT. I am a doctor, Walter Sackett, a practicing physician in Miami for 30 years and a member of the Florida legislature for 4 years.

The Honorable J. Enoch Powell, Minister of Health in the United Kingdom for 3 years, says in his book "Medicine & Politics" (see Appendix I) that when the recipient pays no money for medical care, he has no sense of responsibility. Also, that:

> The vulgar assumption is that there is a definable amount of medical care "needed" and if that "need" was met, no more would be demanded. This is absurd, as every advance in medical science creates new needs . . .

The difference between a legislator's and doctor's viewpoint is important. For a doctor, the general law is relevant only as it helps or hurts the individual. For a politician, the individual case is relevant only insofar as it illuminates the general law. For a Government employee, the individual case must be subordinated to some general rule. Uniformity is demanded which causes quality of medical care to suffer.

INDIVIDUAL VERSUS COMMUNAL RESPONSIBILITY

Mr. McNerney, national head of the Blue Cross Association, as agent for the National Government obtains large sums of taxpayers' money, and as a chairman of a task force on medicaid and related problems, recently reported that:

> The country today is well into a transition from considering that health is largely an individual affair to understanding that health is necessarily a community affair.

This is basically wrong—it is patently evident the primary responsibility for a competent individual's health rests in that individual himself. Communal interest is no substitute for self interest and, therefore, cannot replace it.

THE TACTICS SAME TO PROMOTE SOCIAL SECURITY AS MEDICARE

Madam Perkins in 1962 reported to HEW employees how the Social Security Act was passed. This HEW publication gives the uninitiated a glimpse how power is manipulated.

> We got advice. All these actions were for the purpose, not so much of advice as of propaganda. The constitutional problem was the greatest one. How could you get around this business of the State-Federal relationships? Justice Stone supplied the solution: "The taxing power, my dear, the taxing power. You can do anything under the taxing power."
>
> This is the reason of course that we built so strongly on the taxing power and the whole system of taxation is the basis of the Social Security Act. We gave way on washing out universal insurance; that is, universal coverage. We let them take out one group after another; no objections, just so we got the basis of the bill.

In establishing the principle of medicare the same tactic was used. Proponents said: "If we can only break through and get our foot inside the door, then we can expand the program after that."

The advocates of medicare got their foot inside the door, established the principle, and here in this legislation, are seeking to expand the program. Mr. McNerney's task force report on medicaid sheds light on what the Federal interventionists intend. For example: "The escalation from individual need to community crisis, to public decisionmaking, is the choreography of social action in a democratic society."

THE POOR ARE MERELY THE EXCUSE

"To infer from our recommendations that steps need to be taken only with respect to the provision of health care services for the poor and the medically indigent, would be to lose completely the significance of our criticisms as well as the opportunity for great progress." Bismarck's great discovery—long before McNerney—consisted in a device for making political capital out of poverty and human suffering.

MEDICREDIT

The dangers and defects of Government intervention cannot be avoided by calling it "voluntary medicredit." It is a trap because: Government is to pay; therefore, it will control; but, demand will exceed supply due to the absence of the restraining force of individual responsibility. Former Secretary Celebrezze said of the Bow bill—medicredit principle—"It will require stringent Government controls on the insurance industry."

The scheme of subsidy and special privilege to closed panel, per capita prepayment group practice in the bill (H.M.O.) is another foot-in-the-door trick. (See app. V)

It is designed to expand it to people under 65; increase Government expenditures; is not new; is backed by Mr. Wilbur Cohen, the UAW, Mary Lasker and Mr. Rockefeller. HEW has propagandized for it for years; it did not grow in competition as its Government promoters hoped; State laws are to be attacked with HEW money.

Dr. Garfield, director if the Kaiser plan admits: extending Government health insurance to the entire population would compound demand; is folly; will result in serious deterioration in quality and availability of services for the sick; after years we learned that when fee-for-services is eliminated the regulator of flow into the system is gone, worried—will usurp doctor's time and interferes with care of the sick; and freedom of choice of alternative systems is preferable for both the public and physician.

It is regrettable that time did not permit us to fairly show why the United States is so healthy and prosperous under freedom. We urge you to study the more complete material we have briefly submitted. Please send us questions which we will be happy to answer for the record. The best system in the world deserves to be defended without compromising principle.

Thank you, gentlemen.

(The prepared statement and appendixes follow. Hearing continues on p. 373.)

Statement of the Association of American Physicians and Surgeons

The Association of American Physicians and Surgeons is a nationwide Association of doctors with membership in over 1,300 counties, in all of the 50 states, and Puerto Rico, and in the District of Columbia. The members seek through this Association to protect the responsibility, independence and freedom of doctors and patients.

We appreciate this opportunity to present our views on the legislation before you at this time.

We are deeply concerned about the trend of this legislation which extends Medicare and revises Medicaid. Our concern deepens as we study the report of your staff on Medicare and Medicaid problems in which the failures of these programs are admitted. We are not reassured by the admissions in a recent HEW Task Force report on Medicaid. Also, statements of the Administration advocating deeper and deeper government intervention into medicine disturbs us. Also, apparently well intentioned, but misguided, efforts to perpetuate these admitted failures—with doctors policing other doctors in an attempt to make an inherently unsound approach work needs careful examination in the light of fundamental principles.

Government intervention in medicine is fraught with profound moral, economic and political consequences which are presently only gradually being explored and understood. These consequences are widely misunderstood by the profession and public alike, as being accidental, transitory, easily remedied or due perhaps to the weakness of a particular approach, employee or administration. This is not so. The strains and stresses, the inadequacies and dissatisfactions which the profession and public experience are implicit in the nature of government intervention itself.

Medicare and Medicaid are in trouble

After five years of Medicare and Medicaid these "programs are in serious financial trouble." Costs have soared and waste is so apparent, that it is now admitted:

> The two programs are also adversely affecting health care costs and financing for the general population.

As you will recognize, these are statements from your staff's report of February, 1970 exposing the situation. We thank you and your staff.

These programs are in such difficulty that about one year after Medicare and Medicaid started taxes were increased 25%. Now it is proposed to further increase taxes by many billions of dollars. Without these increased taxes HEW admits that funds will be exhausted in less than 1½ years.

HEW spending exceeds all corporate profits; GNP of Canada, etc.

However, the situation is even more grave than government reports disclose. For example, the entire Department of HEW is now spending at an annual rate of over 59 billion dollars per year. This is more than all the profits after taxes of all the corporations of the United States (58 billions vs. 48.5 billions of profits after taxes). It is the most expensive non-war operation known—exceeding the 57 billion dollars gross national product of the entire 20 million people of Canada. Legislation which has passed the House would increase HEW spending another 4½ billion, increasing the spending by HEW alone to over 63 billion dollars. This is over 50% of the gross national product of either West Germany, Japan, the United Kingdom, France or Italy. (Statistics for socialist countries such as the U.S.S.R., etc. are not published.)

Yet, H.R. 17550 proposes that HEW spend more.

Your staff states:

> Unless the rapid and continuing escalation of the costs of health care are moderated, the Congress may reasonably anticipate increasing pressures upon it to extend the Medicare and Medicaid programs to encompass large segments of the population not now covered under these public health payment plans.

Wrong key

It is suggested that Medicare and Medicaid can be made to work more efficiently and economically by tightening government controls and administration. The report states:

The key to making the present system workable and acceptable is the physician and his medical society.

The suggestion is made that the profession needs to "police and discipline itself" and that—

> Prompt action is necessary by organized medicine (and other health care professions) to do what is required with respect to monitoring care provided and charges made for the care.

Your staff has sounded this warning:

> We fear that virtually insurmountable pressures will develop for alternative control procedures which may be arbitrary, rigid and insensitive to the legitimate needs of both the patient and his physician.

WELFARE AND THE POLICE STATE

The fear expressed should not be surprising. In the book "Compulsory Medical Care and the Welfare State" Melchior Palyi clearly described the growth and extension "of governmentalized medical care systems on the Continent of Europe and in England."

The Key to making the present system workable and acceptable is "NOT the physician and his medical society" but rather for the elimination of the excessive spending and interference generated by these programs.

POLITICIAN VS MEDICAL CONSIDERATIONS

The fact is that political medicine is *bad medicine*—not because politics is bad and medicine is good, but because the two do not mix. Wherever medicine has been dominated by politics, it has been bad. These facts are well known:

1. Competition for votes results in promising *more* quantity and quality of medical benefits are available. (The hospitals, doctors, nursing homes, nurses, etc. required to provide this care on the level promised, or the electorate thinks is promised, do not exist.)

The record speaks for itself. Political promises have been made that government will give benefits with:

(1) Little or no cost to beneficiaries.

(2) No governmental interference in, or control of the practice of private medicine;

(a) Patients are promised freedom of choice of hospital and physician;

(b) Physicians are promised freedom to choose where to practice with freedom to exercise independent, professional judgment in diagnosing, prescribing, and caring for patients. Also, they are promised that they will be free to serve whom they choose at fees not fixed by government. It is promised that government will pay usual and customary fees—that doctors may look to their patients for full reimbursement of charges. Thus, the patient would be responsible for the difference between the doctor's bill and the amount allowed by government.

The publisher says "He makes clear how these services have been used in all countries to augment and strengthen control by politicians and bureaucrats. In addition, he has provided insight into the origin and development of Welfare State doctrine and deeds." In 1949 the publisher said:

> During the past few years most Americans have begun to comprehend that vast revolutionary forces are in ferment in this country. It must be understood that the establishment and extension of Welfare State concepts and mechanisms lead to an inevitable end. If implemented here, they ultimately would mean for America, the frightening confusion that is Europe, the tragic austerity that is England, and the Godless despair that is Russia."

ACTION NEEDED

We agree that *prompt action* is necessary, but not by doctors. Prompt action should be taken by government to stop this reckless spending and waste. The actual crisis faced by the United States results from the lack of discipline, control and restraint by the central government. Excessive government spending and interference in the name of the Welfare State is a major cause of our current trouble. Doctors did not ask for these programs. In fact, we warned strongly against them. They have failed.

2. Expectations of voters rise, they believe that everyone will be able to have all the medical care he wishes. All will be equal. All will get the best.

3. Voters believe that *hard choices* will no longer be the *individual responsibility* of the patient. He will no longer have to choose between using earnings for medical care needs as well as for housing, clothing, food, education, automobiles, colored TV, liquor, tobacco, vacation trips at home and abroad, recreation, etc. *The Government will take care of almost anything.* (Except a promised small ($1.00) monthly payment for medical care.) Former President Johnson, when Vice-President, said: "Why anyone would want to deny a person the opportunity of putting in a $1.00 a month, along with his employer, to insure himself through Social Security against the staggering costs of hospitalization simply amazes me."

4. It is promised that utilization review committees are required—not to interfere with medical judgment or practice—but to be sure that doctors do not put patients in hospitals unnecessarily or keep them there too long. Who judges is left vague in the law.

5. Executive Branch employees' estimates of costs to the public treasury, and for taxes are low. Such low estimates are accepted by some legislators who tell voters how much they are doing *for* them and skillfully avoid telling them what they are doing *to* them.

ALL OF THE FOREGOING ESTIMATES HAVE PROVEN TO BE UNREALISTIC AND THE REPORTS OF YOUR STAFF FOR THE MOST PART SO INDICATE. THE REASONS ARE CLEAR.

When the individual was relieved of responsibility of exchanging something of value for the medical services he sought, he felt no responsibility for restraining his wishes.

As a result, the demand for hospital care and doctor visits increased materially. This artificial demand for hospitals and doctors forced costs up to government and private seekers of services alike.

Taxes were increased. Government force was used to begin enroaching upon private practice.

Physician and hospital employment of more clerical help to fill out government forms was required. Doctors were forced to divert time from the care of patients to supervise reporting and often had to make lengthy justifications of why they did what they thought was necessary at the time of decision.

Expensive, cumbersome and inefficient government administrative procedures, for control of use and cost and for research in improving medical care, diverted doctors and other scarce medical personnel from patient care.

As the costs mounted, doctors and hospitals were blamed for higher utilization and costs without meeting demands. Now additional price-fixing and more red tape are being threatened. Poorer quality care will be the inevitable result.

This key principle must be re-emphasized—it is necessary that the individual patient must be responsible to obligate himself in order to keep his wishes from being considered rights without duties thus causing demand to completely outrun supply. The individual patient and individual doctor must exercise independent, responsible judgment if we are to have good medicine. The doctor and patient are closest to the problem and are most competent at the time to make the best decisions for everyone concerned. If responsible individuals acting as such do not curtail irresponsible demand then government will ration demand on a political basis.

Not only are national government and state governments in trouble because of uncontrolled welfare spending, but Britain is in similar trouble.

The Honorable J. Enoch Powell, Minister of Health in the United Kingdom for three years, in a book: *Medicine and Politics*, points out that when the recipient pays no money at point of service for medical care, he has no sense of responsibility and from this many real problems are created. He says:

> Common thought and parlance tend to conceal or deny the fact that demand for all practical purposes *is* unlimited. The vulgar assumption is that there is a definable amount of medical care 'needed' and if that 'need' was met, no more would be demanded. This absurd. Every advance in medical science creates new needs that did not exist until a means of meeting them came into existence, or at least into the realm of the possible.

INFINITY OF DEMAND

> There is virtually no limit to the amount of medical care an individual is capable of absorbing; everyone knows that he suppresses or ignores medical conditions that could be alleviated or removed.

In an appendix hereto you will find a number of quotes from Mr. Powell which are pertinent to the situation that we now face.

NO COUNTERPART IN MEDICINE

As a politician, you understand and instinctively ask yourself: "What will be the cost in dollars to the nation if Mrs. X is paid more—will it on balance be against the public interest?" This is an essential part of a politician's duty *but has no counterpart in the professional activity of a doctor.*

> For a doctor, the general law is relevant only as it helps or hurts the individual.
>
> For a politician, the individual case is relevant only in so far as it illuminates the general law.
>
> For a government employee, the individual case must be subordinated to some general rule. Uniformity is demanded. Government employees (including utilization and review committees, as well as ordinary clerks) being ignorant of the facts and remotely involved, often require lengthy, detailed written justifications from busy doctors who would be more advantageously employed caring for patients.

INDIVIDUAL VERSUS COMMUNAL RESPONSIBILITY

Mr. McNerney, head of the Blue Cross Association, which is an agent for the federal government and obtains large sums of money as the result of government contracts, as Chairman of a Task Force on Medicaid and related problems, reported to the Secretary of HEW:

> The country today is well into a transition from considering that health is largely an individual affair to understanding that health is necessarily a community affair (letter June 29, 1970).

This is where the government interventionist is wrong. It is patently evident that the primary responsibility for a competent individual's health rests in that individual himself. The competent adult determined to eat, drink and indulge in hedonistic pleasure to excess is headed for health problems. Communal health services have nothing to do with it. The individual has everything to do with it. Communal interest is no substitute for self interest and, therefore, cannot replace it.

A community in which each competent individual is interested in his own health will be a healthy community and vice versa. Doctors instinctively and properly resent and resist third party interference, be it governmentally directed, by Blue Cross, Blue Shield, insurance companies acting independently, or as agents of government.

National government reports and records show conclusively that: *Social Security laws are being used to gradually reverse this country's concept of the proper relationship of the individual to government without the public understanding that fact or consenting to it.* We believe the Founders of this government wisely sought to protect the lonely individual against any tyranny including the all-encompassing danger of government. The real danger of the present age is that social claims will snuff out real personal liberty. The Social Security system has powerful advocates and incomprehensible billions of dollars of public funds available in it for promoting its own expansion while personal values and freedoms are in danger of being trampled on.

TACTICS PROMOTING SOCIAL SECURITY AND MEDICARE THE SAME

The history of Medicare by HEW brings into focus how this gradual reversal has been brought about. Madam Perkins provided a record for the uninitiated to get a glimpse of how these matters are manipulated behind the scenes. As former Secretary of Labor under President Roosevelt, she reported to HEW employees a few years ago how the Social Security Act was passed.

> We got advice. All these actions were for the purpose, not so much of advice as of propaganda.

The Constitutional problem was the greatest one. How could you get around this business of the State-Federal relationships? It seemed that it couldn't be done. Speaking to Justice Stone, I said. "Well you know we are having big troubles, Mr. Justice, because we don't know in this draft of the Economic Security Act, which we are working on—we are not quite sure you know what will be a wise method of establishing this law. It is a very difficult Constitutional problem, you know. We are guided by this, that and the other case." He looked around to see if anyone was listening. Then he put his hand up like this, confidentially, and he said, "The taxing power, my dear, the taxing power. You can do anything under the taxing power." This is the reason of course that we built so strongly on the taxing power and the whole system of taxation is the basis of the Social Security Act.

We had a General Advisory Committee which was the employers and laborers—the general public. They were easier to handle because the "general public" had been well picked; you know the way you pick a committee. Even the employers had been well picked. There was Marion Folsom of Eastman Kodak Co., etc.

The result was a bill that finally was presented to Congress and . . . was debated briefly; when you think of the problems involved, only a decent amount of debate—and we gave way on all kinds of things. We gave way on washing out universal insurance; that is, universal coverage. *We let them take out one group after another; no objections, just so we got the basis of the bill.*

Thus, the questionable principle of Social Security was established. We say questionable principle because it violated the division of responsibility between the national government and the states which was clearly intended by the Founders and no amendment has been made to the Constitution which changed those intentions. As you know, most of the groups which Madam Perkins had taken out at the time to ease passage, rejoiced at being clever but subsequently have been gradually forced under the law. In recent years, even tips of cab drivers and waiters have been included. The various groups did not stay united for freedom and as a result lost some of their freedom.

In establishing the principle of Medicare the same tactic was used. Proponents said:

> If we can only break through and get our foot inside the door, then we can expand the program after that.

The advocates of Medicare got their foot inside the door, established the principle, and here in this legislation, are seeking to expand the program. Mr. McNerney's Task Force Report on Medicaid sheds light on what the federal interventionists intend. For example:

1. The escalation from individual need to community crisis, to public decision-making, is the choreography of social action in a democratic society.

2. ". . . the day is past when doctors and hospital administrators and trustees and their associates may rely on their own judgments as to how they can best distribute all the skills and resources at their disposal, to what they see as the greatest advantage for the people they should be serving."

POOR MERELY THE EXCUSE

3. "To infer from our recommendations that steps need to be taken only with respect to the provision of health care services for the poor and the medically indigent, would be to lose completely the significance of our criticisms as well as the opportunity for great progress." Bismarck's great discovery—long before McNerney—consisted in a device for making political capital out of poverty and human suffering.

TARGET INCLUDES PRIVATE INSURANCE

4. "Private insurance and voluntary, non-profit prepayment are all subject to the criticism that they have been too much geared to the payment of claims and insufficiently geared to the cost implications of the incurred utilizations."

MUST BE MADE MORE ORDERLY

5. "Only as orderly financing of this expensive service to citizens throughout the land becomes a matter of high political priority, do we realize that the delivery of care, its pricing and its prepayment must be made more orderly, more economical and more generally satisfactory to the public at large."

OUTSTRIP EXISTING TAX RESOURCES

6. ". . . the Medicaid program . . . could . . . outstrip existing federal, state tax resources within the next 5 to 10 years."

JEOPARDY

7. The report admits that Medicaid: ". . . may jeopardize the operation of the entire . . . system . . ."

FAR GREATER GOVERNMENT COSTS

8. The report admits: ". . . will call for fiscal commitments far beyond any that have as yet been made by state and federal governments."

MEDICREDIT

The dangers and defects of government intervention cannot be avoided by calling them "social insurance," "voluntary Medicredit," or "security" of some kind. The voluntary Medicredit proposal is a TRAP. It would provide for the universal purchase of private, comprehensive medical and hospital insurance—the premiums for which would be deductible from income taxes. Low income taxpayers would be issued certificates redeemable by the Treasury.

Medical talent already is scarce in relation to demand as demonstrated by Medicare and Medicaid failures Government intervention regardless of how initiated will aggravate the scarcity. We are back to the proposition that there is no adequate substitute for the private individual responsibly restricting demand by making difficult choices.

Also, in the case of Wickard versus Filburn the courts said, in effect—the government can control anything it subsidizes. Former Secretary of HEW Celebreeze (testifying on the Bow Bill which embodied the Medicredit principle) said: "If we ever get to the point under the Bow Bill of private insurance companies receiving so much subsidy, direct subsidy from the federal government, I am fearful that it would be only a matter of time before more stringent government controls would have to be applied to the private health insurance companies." p. 53 House Ways and Means Hearings, 1963.

CONCLUSION

The attached appendices give additional pertinent information as to why we are so concerned about:

1. The trend of this legislation to subsidize closed-panel per capita group practice as a "BLUE PRINT" for government control of more medical practice.
2. The admissions in the report of your staff.
3. The admissions in an HEW staff report.
4. Other statements of the administration advocating deeper and deeper government intervention in medical practice.
5. Plans to "police" private practice by medical associations acting as governmental agents.

Association of American Physicians & Surgeons maintains its original position that Medicare and Medicaid violate the clear intentions of the Authors of the Constitution and that those provisions have never been set aside by an amendment enacted in a manner as provided in the Constitution itself; that these programs are bad proposals which have resulted in predicted and predictable astronomical costs, over-utilization, and, contrary to the letter of the law, interfere in the delivery of medical care. They should not be expanded.

The outstanding successes of the United States are based on the freedom of individuals to enjoy the fruits of their labor and to develop and exercise their God given talents in a responsible manner without government interference.

Build on that principle and you will enhance the nobility and happiness of America. Degrade it and you will destroy the last bastion of freedom in the world today.

Appendix I

"A new look at medicine and politics"—The right honorable J. Enoch Powell, M.D.E., M.A., M.P.

Introduction

Since medicine has become inextricably involved with politics, and the organization of medical services sometimes seems to have assumed more importance than the quality of those services, a new look at medicine and politics is badly needed. Few people can be better equipped to supply this new look than ex-minister of health.

We may sometimes regret the days when th doctor, G.P. or specialist, was the independent practitioner of a highly skilled art, answerable to no one but his own conscience and the corporate conscience of his colleagues for the standard of the care he gives his patients, and asking—and very often waivering—a direct monetary return for his services. Now, since the National Health Service, the hospital doctor is a State employee and the general practitioner is a contractor to the State. Such a change in the setting of medicine is fraught with profound consequences, which are still only gradually being explored and understood. These consequences are widely misunderstood, by profession and public alike, as being accidental or transitory or easily remedied, due perhaps to the weakness of a particular Minister or the faults of a particular g 'ernment. Mr. Powell shows that this is not so. The strains and stresses, the inadequacies and dissatisfactions, which the profession and the public experience, are implicit, he argues, in the nature of a free, comprehensive national health service itself. (From the introduction to *Medicine and Politics.*)

"From the point of view of its recipients, Exchequer money is for all practical purposes unlimited. The consequences elsewhere of an increase in a particular expenditure are infinitely remote and unascertainable, and no sense of responsibility for justiying even the present level of expenditure is felt by those concerned." P. 15.

". . . In one case people feel 'involved' and therefore, responsible, in the other they do not." P. 18.

"The necessity which is proverbially the mother of invention is least fecund when she is presented in the guide of his majority's treasury." P. 20.

"Financing of a service by the public and especially Exchequer, money converts every limit upon demand into an arbitrary and perverse or even malevolent decision imposed by conscious authority." P. 20.

"In a publicly financed service, remuneration of the employee is seen as an arbitrary evaluation placed upon people and their work by a political authority." P. 21.

"But the moment the employer or the paymaster is the Exchequer, it is assumed that he has the power to pay more at will, and so what is actually paid or offered, is treated as a deliberate evaluation of the employee by the employer, and resented accordingly." P. 21.

"You do not hear artists, or clergymen, or monks, or missionaries, or actors, or novelists complaining that their sense of vocation is being exploited. Nor did the doctors or the nurses or the dentists do so before the Exchequer became paymaster." P. 23.

"With the medical profession. . . . the supply can adjust itself to change in demand only after a more or less substantial interval of time." P. 24.

Supply and Demand

"Medical care under the National Health Service is rendered free to the consumer at the point of consumption." P. 26.

"Consequently supply and demand are not kept in balance by price. Since, therefore, resources are limited, both theoretically and in practice at any given time, or the demand is unlimited, supply has to be rationed by means other than price. The forms of rationing adopted deliberately or by default, and usually unrecognized certainly unproclaimed as such, are among the major irritant ingredients in Medicine and Politics. P. 26.

"Common thought and parlance tend to conceal or deny the fact that demand for all practical purposes is unlimited. The vulgar assumption is that there is a definable amount of medical care 'needed', and that if that 'need' was met, no

more would be demanded. This is absurd. Every advance in medical science creates new needs that did not exist until the means of meeting them came into existence, or at least into the realm of the possible. For every heart-lung machine or artificial kidney in operation there must be many times that number of cases to which the treatment would be applicable. Every time a discovery is made in, for example, the techniques of grafting, the horizon of 'need' for medical care is suddenly enlarged." P. 26.

"There is a characteristic of medical care that makes its public provision exceptionally problematic. The demand for it is not only potentially unlimited; it is also by nature not capable of being limited in a precise and intelligible way." P. 28.

"The National Health Service, then, must and does apply covert rationing devices in order to limit demand to the actual amount of the supply." P. 29.

"In fact, the Minister does exercise substantial control over the volume of service provided, but he does so indirectly through his power to fix what remuneration the executive councils shall offer to the practitioners in contract with them. If this remuneration were such as to attract into contract with the councils rapidly increasing numbers of practitioners, then indeed the volume of service rendered and consequently by the expenditure would 'go through the roof'." P. 30.

"Indeed, in the last three years the number of general medical practitioners in the service has actually begun to fall at a rapidly accelerating pace." P. 30.

". . . the volume of private practice . . . is so trivial that many decline to accept private patients at all, on the ground that the accounting, billing and other separate arrangements would cost more than they were worth." P. 34.

"It is a common error to suppose that a cash relationship is inconsistent with mutual respect between professional and client, or is synonymous with selfishness or irresponsibility. A glance at any of the non-nationalized professions proves the contrary. The question is rather whether a tolerable and satisfactory relationship between general practitioner and patient can exist when there is no cash nexus." P. 35.

". . . good and bad service (in similar circumstances) are remunerated at one and the same price. A capitation fee can no more distinguish between good and bad service than a fee per item of service, which governments have consistently rejected." P. 37.

"Thus, outside as well as inside the hospitals the figure on the supply side of the equation is fixed at any particular time by those complex forces that determine that state's decisions on expenditure. With this figure demand has to be brought into balance. Virtually unlimited as it is by nature, and unrationed by prices, it has nevertheless to be squeezed down somehow so as to equal the supply. In brutal simplicity, it has to be rationed; and to understand the method of rationing is also essential for understanding Medicine and Politics. The task is not made easier by the political convention that the existence of any rationing at all must be strenuously denied. The public are encouraged to believe that rationing in medical care was banished—being applied to medical care is immoral and repugnant. Consequently when they, and the medical profession too, come face to face in practice with the various forms of rationing to which the National Health Service must resort, the usual result is bewilderment, frustration and irritation.

"The worst kind of rationing is that which is unacknowledged; for it is the essence of a good rationing system to be intelligible and consciously accepted. This is not possible where its very existence has to be repudiated." PP. 37 and 38.

"So it is always arranged that there shall be plenty of people waiting when the great man arrives, so that there is no danger of the expensive mill even momentarily lacking grist." P. 38.

"There has to be some differential rationing for different qualities of an article, and if not price, then, for example, time: better surgeon, longer wait, and vice versa." P. 39.

"Generally, the waiting list can be viewed as a kind of iceberg: the significant part is that below the surface—the patients who are not on the list at all, either because they are not accepted on the grounds that the list is too long already or because they take a look at the queue and go away." P. 39.

"Short of dying, however, they frequently get bored or better, and vanish. Here again, time on the waiting list is a commutation not only for money—measurable by the cost of private treatment with less or no delay—but also for the other good things of life. It is an interesting phenomenon of the waiting lists

for in-patient treatment that at the holiday season and around Christmas time it may be necessary to go quite far down a lengthy waiting list to get patients willing to accept the long-awaited treatment in sufficient numbers to keep even the temporarily reduced hospital resources fully employed." P. 39.

"I cannot but reflect sardonically on the effort I myself expended, as Minister of Health, in trying to 'get the waiting lists down'. It is an activity about as hopeful as filling a sieve, although this is not to deny that some of the measures applied and pressures exerted might conceivably have had some useful side-effect in improving, in a slight degree, the direction of effort. There were the circulars enjoining such devices as the use of mental hospital beds and theatres, or of military hospitals. There were the stiff cross-examinations of staffs and hospital authorities in the endeavour to discover what contumacy might explain their continued non-compliance with the official exhortations. There were the special operations to 'strafe' the waiting lists, urged on the fallacious ground that a stationary waiting list is not evidence of deficient capacity—otherwise it would lengthen—but of a backlog which, once 'cleared off', ought not to be allowed to recur." P. 40.

"Alas, the waiting list that melted under an assault of this kind was back again to normal before long. There were always special, local and temporary explanations that could be cited, such as a sudden coincidence of staff off duty through leave, sickness or change of post. But all too evidently the causes at work were general and deep-seated. There was a mean around which the figures fluctuated, but that was all. Naturam expellas furca tamen usque recurret: though you drive Nature out with a pitchfork, she will still find her way back." P. 40.

". . . when they say that for cases diagnosed as urgent or critical the waiting list, practically speaking, does not exist. This is far from disproving the function and necessity of the waiting list as a rationing device. For one thing, 'urgent' and even 'critical' are not objective magnitudes; on the contrary, they are assessments that have already taken the volume of supply into account. In any case, there is no clear-cut dividing line between the 'urgent' cases, seen or treated at once, and the 'non-urgent' cases on the waiting list—or, as the case may be, not on the waiting list at all. The latter are squeezed down—or off—by the former. To point to the fact no 'urgent' case goes untreated as evidence that supply and demand can be brought into balance without rationing is like arguing in a famine that because nobody dies of starvation, there need have been no rationing system." P. 41.

"The supply of medical care of all kinds through the National Health Service is rationed by forcing the potential consumer to choose between accepting the quality and quantity offered or declining the care offered. If he declines the care offered, he can either renounce or defer treatment altogether or he can endeavour to purchase it outside the National Health Service." P. 41.

"There is, as has been said above, no reason to suppose that an increase in the quantity or quality of care provided by the National Health Service would reduce the need for rationing. On the contrary, every increase in eligibility must involve an intensification of the other forms of rationing, such as waiting." P. 43.

"The result is to impart a unique rigidity and centralisation to the conduct of the activities of something approaching half a million persons in a vast variety of institutions throughout the country. The effects are felt both in the relationship between the state and the professions and in the form the development of the service takes." P. 44.

"In the professions it promotes the sense of being subordinate, in a professional capacity, to lay control and decision. In the last resort, all final decision is lay, whether the decision be that of an individual to undergo an operation or of Parliament to institute a national health service. The principle is not limited to medicine but is universal: the professional is the servant, albeit specially endowed and equipped, while the layman (albeit often called the 'client') is the consumer who commands the service and decides whether he will take the advice or no. In all government the last word is of necessity lay, that is, non-expert: . . ." P. 44.

"The idea therefore that the professional could ever be 'on top', like that of a state health service controlled by the doctors, is a chimera." P. 45.

". . . the amount of private medical care, by volume or value, is between one and two per cent of the value or volume of medical care in the National Health Service." P. 70.

"Thus a voucher scheme resolves itself merely into a method of increasing state expenditure upon medical care." P. 72.

APPENDIX II

CRITIQUE OF RECOMMENDATIONS OF THE TASK FORCE ON MEDICAID AND RELATED PROGRAMS, JUNE, 1970, U.S. DEPARTMENT OF HEW

The HEW Task Force on Medicaid includes long time advocates of government interventionist i.e. Bert Weidman, Director of Social Security Department AFL-CIO; Melvin A. Glasser, Director, Social Security Department UAW, Detroit, Michigan; Herman Sommers, Ph.D., Professor of Political and Public Affairs, Princeton University, et al.

The Chairman, Walter J. McNerney, has advocated more intervention for years. Also, the staff work was performed by HEW employees who have public records of working for legislation giving government employees under color of law, authority to control doctors and patients by interfering in private contracts between them.

The Task Force is not representative as it claims to be but is primarily an instrument for national government intervention.

The Task Force Report of June 29, 1970:

Intervention advocated

Calls for intervention without camouflage: 'The road ahead will not be easy; effective intervention will require, etc." p. 2.

Right without responsibility

"The Task Force . . . interprets the recent federal enactments as intending that access to *basic medical care shall be a right*." p. 2.

(The Medical Committee For Human Rights for years headed by Dr. Quentin Young and which upholds the fundamentals of collectivism and opposes our system, used the argument that health care is a right in an article attacking the AMA in the New York Times. Since then, a planning Committee of AMA headed by Dr. Himler of New York has advocated the same position as the M.C.H.R. This is a semantic TRAP to give central government power over the lives of individuals by promoting individual irresponsibility and collectivist responsibility.)

The Task Force admits it is "setting the stage." p. 2.

States denigrated "the promise of Medicaid that some care, at least, would be available to all who needed it, has vanished into the obscurity of state determinations of eligibility and the limitations of state resources and priorities." p. 3.

Centralizers who staffed this Committee, selected it, and dominate it, dislike state programs. Medicaid was only a temporary tactic toward total centralization. Here they are belittling this interim program.

Attacks our system

Advocates more central government usurpation of power in these terms: "The Task Force is strongly convinced that the current health system has serious organizational, financing, productivity, and access problems and that bolder moves than have characterized the last few years are needed to achieve measurable improvement." p. 4.

No prescription?

Denies they have a prescription for a new system "The Task Force has no prescription for new health-care delivery system." p. 4. (The following facts contradict this:)

Prescription is closed panel, per capita, prepay group

We recommend supplementary plans financed by government to provide service "through a group practice prepayment plan, . . ." p. 24.

(This isn't surprising since Dr. John Cashman of HEW of the Public Health Service is one of the HEW personnel who staffed the Committee and in HEW Bulletin 1750 dated October, 1967 during the reign of Wilbur J. Cohen as Secretary, said in a speech entitled "A Blueprint for Action" "This conference is to lead to action, and describing that blueprint is my exciting task this morning." The theme of the meeting was "*How* to promote, not whether." This is the basis of H.M.O. in HR-17550.)

Managed system

Admits it is working to have HEW manage the system. "To safeguard the system . . ., it must be managed." p. 5.

"Specifically in the Department of Health, Education and Welfare." p. 5.
(This is not surprising realizing that HEW selected the Task Force and provided all of the staff work on this 200 page report.)

Regulation

It characterizes its demands for regulations as "with the necessary minimum of regulation." p. 6.

Crisis

It uses the scare technique of saying "we have a system of crisis medicine . . ." p. 6.

Manipulation

The concept of manipulation is further disclosed in the statement "otherwise, the trade-offs required in the judicious use of scarce resources cannot be made rationally." p. 6.

Philosophy

The basic philosophy that this country is to be run primarily through private contracts of individual citizens is repudiated thus: "The field not only needs . . . money . . . it also needs a sounder philosophic framework . . ." p. 7.

Who—Whom?

There can be no doubt who intends to dictate to whom ". . . the day is past when doctors and hospital administrators and trustees and their associates may rely only on their own judgments as to how they can best distribute all the skills and resources at their disposal to what they see as the greatest advantage for the people they should be serving." p. 8.

The basic scheme

The report goes on to say "the escalation from individual need to community crisis to public funding to public decision-making is the choreography of social action in a democratic society." p. 8. (This sums up in a nutshell what the government interventionists are up to.)

Disaster

The report admits that many in the health professions believe such action of interfering will be "unmitigated disaster . . ." p. 8.

Control with minimum abrasion

They seek to impose these outside controls "with minimum abrasion." p. 8.

Control

An attitude of direction and control permeates the report. For example, speaking of consumer participation, the report goes on to say "the leadership of the individual institutions and programs and ultimately state and federal programs which must provide guidance and initiatives aimed at making consumer participation informed and responsible." p. 8.

Admits control is its strategy. "The basic rationale behind these recommendations is . . . control." p. 10.

Claims it is representative when it clearly is not. p. 8A.

Planning

"Care as a right—requires conscious planning." p. 10.

Poor only excuse

Helping the "poor" isn't the target. The "poor" aged was the excuse but now—"to infer from our recommendations that steps need to be taken only with respect to the provision of health care services for the poor and the medically indigent would be to lose completely the significance of our criticism as well as the opportunity for great progress." p. 13.

Private insurance next?

"Private insurance and voluntary non-profit prepayment are all subject to the criticism that they have been too much geared to the payment of claims and insufficiently conditioned to the cost implications of the incurred utilization." p. 13.

Politics to dominate

Political considerations are to dominate medical practice. "Only as orderly financing for the provision of these expensive services to citizens throughout the land becomes a matter of high political priority do we realize that the delivery of care, its pricing, and its prepayment must be made more orderly, more economical, and more generally satisfactory to the public at large." p. 14.

Headed for bankruptcy

The report admits the present program is headed for bankruptcy. ". . . the Medicaid program, . . . could . . . outstrip existing federal, state tax resources within the next five to ten years." p. 20.

Dangerous

The report admits Medicaid is dangerous. ". . . may jeopardize the operation of the entire . . . system. . ." p. 20.

Admits costs are going up greatly. ". . . will call for fiscal commitments far beyond any that have as yet been made by state and federal governments." p. 21.

100% central take over

Would drop all pretense of the state government having any part in the program and have the central government take over 100%. "We recommend converting Medicaid to a program with the uniform minimum law of health benefits financed 100% by federal funds, . . ." p. 23.

The big ideas

(1) Control

A summary is included at the end of the report entitled "*The Big Ideas*." The report candidly states: "For all the variety of subject and substance, the recommendations without exceptions relate in one way or another to the needs of consumers of health care, or the behavior of providers of health care or the instruments including money, that can identify the needs and guide the behavior." Note: "Guide the behavior." Control is the heart of the matter. By whom and by what authority? Summary. p. 1.

(2) Plan and manage

"The second big idea is that the health care delivery system . . . must be planned and managed. . ." Summary, p. 7.

Who judges need?

"In fact, if a benevolent and affluent government were to begin to pay for all the basic health care needed by all those who can't pay for it themselves, but no other change were introduced into the existing system, the result would be a disastrous rise in the cost of services that are already scarce. There isn't enough money and there aren't enough doctors to provide the needed care just on a fee-for-service basis; thus any solution will require new options, new goals and new attitudes." Summary, p. 7. From this there can be no doubt what they intend to do and that is, destroy the system that has evolved in this country under the principle of individual responsibility. The last sentence is devoted to the idea of controls. "Conducting on sight reviews of program performance to assure compliance with policies and regulations."

Appendix III

Why the Clamor for Socialized Medicine?

(By Robert J. Myers, former Chief Actuary of Social Security)

These are excerpts from a speech by Mr. Myers, who resigned his post last May to protest socialist expansionism in Social Security. July 30, 1970.

One might well wonder why there is currently such a clamor for national health insurance or similar programs at this moment. *Medical science has been making giant steps of progress, and the health and longevity of the American public is at an all-time high.*

The advocates of socialized medicine have seized this particular opportunity to achieve their goals or advance toward them, since they believe that the public can be aroused by the sizable increase in medical-care costs. These advocates

made a strong drive for national health insurance—preferably of the socialized medicine type—in the 1940's, *but they failed to achieve their goal because of the general growth* of private health insurance then (which they said could never achieve the success that it actually has).

After laying low for two decades, during which they sought to get the camel's nose in the tent through the enactment of Medicare, these advocates of socialized medicine are again out in the open in full force, using as their appealing argument the recent large increases in medical-care costs. As propagandists, they are quite willing to ignore and leave unmentioned several significant and crucial facts.

1. The largest increases in medical care costs have been for hospitalization—an area that is considered sacrosanct, because 95% of the short-stay hospital beds are in "nonprofit" institutions.

2. *The relative trend of physician fees in the past five years has been almost exactly the same as it was in the preceding two decades—namely, increasing at about the same rate as the general earnings level.*

3. *The illusion is fostered that, somehow or other, insurance is magic and has the inevitable effect of reducing costs.*

In summary, on this point, it seems to me that the advocates of socialized medicine are trying to deceive the general public and sell them their old line of goods under a *new guise—sharply rising medical costs which are unfairly blamed on physicians, when instead they are much more due to the rising general price and wage level and to the trend of hospital costs.*

Nonetheless, Secretary Cohen ignored the actuarial recommendation of a rate of at least $4.40 and instead continued it at $4.00.

He took this action on the grounds that he would, in essence, freeze physician fees (but not other costs under the program) at the existing level—even though he would not be around to see that this was done! Moreover, he had the temerity to say that he was taking this action to help President Nixon, since this would mean less cost to the General Treasury for the matching contributions! *Of course, what he did not say was that his action would virtually bankrupt the SMI Trust Fund—as it has actually done—and would therefore cause his successor greater embarrassment by forcing him to promulgate a much higher premium rate the next time.*

And all this has actually occurred. Secretary Finch found it necessary last December to promulgate the new premium rate, beginning in July, at $5.30 per month.

I do not claim to have the answer as to whether physician remuneration is too high or too low, *but I am convinced that the recent trend in physician fees is entirely justifiable in relation to other prices and to salary levels in general. The justifications made by former Secretary Cohen for freezing physician fees for Medicare purposes do not seem to me to be in accordance with the intent of the law.*

The administrative operation of the SMI program was established with painstaking and costly procedures devised so as to examine closely all charges. *In my opinion, this advance planning was done solely for the eventual control of physician fees on a very stringent and different basis than was originally envisioned in the law.* Some of this rigid control has already come to light, and some people would like to have much more of it in the future. And the apparatus has been constructed to do exactly this!

One might reasonably think that the term "customary charge" means the physician is currently charging his patients, just as though he had a sign listing his fees posted in his office. Instead, the peculiar interpretation has been evolved which says, in essence, *that a fee is not customary until it has been in effect for about six months, and then "custom" cannot change for another year.*

A proposal was made by Secretary Finch that, in the future, the prevailing-charge limits on whatever are determined to be the customary charges of a particular physician shall be the present allowable prevailing charges increased by an index made up partially of changes in the general level of wages and partially of the changes in the general cost level of living. Since the latter usually rises at a lower rate than the former, which rises about the same rate as physician fees, *this would mean that, over the course of time, the prevailing-charges limit would gradually apply completely to each physician, rather than his customary charges.* So, there would eventually be a flat fee schedule under SMI for all physicians in a particular locality, determined by the government.

The physicians of this country have been neatly trapped by the social planners, who secretly envy their high incomes, whether real or only apparent, and thus criticizes them on any possible grounds. The intent of the Medicare program was that persons aged 65 and over should pay the same physician fees as younger persons, and thus should not be second-class citizens by being given lower, "charity" rates. Now that the physicians have charged in this manner, they are severely criticized! If they had artificially held down their fees for Medicare patients, then they would have been subject to the danger that the social planners would have pointed out that Medicare was operating very well and at a low cost and that therefore it should be extended to the entire population. You can't win!

I believe there are grave potential dangers ahead because the political liberals, or expansionists, when they get in office again will make strenuous efforts to change the Social Security program so that it will no longer be a floor of protection.

Instead, these proponents wish to see the government provide virtually complete financial security to nonworking members of our society through governmental means. In the process, they would destroy almost completely all individual efforts through private savings, private insurance, and private pension plans. I believe *that this would have catastrophic effects on people as individuals and, further that it would have the side effect of greatly weakening or destroying our private enterprise system because of drying up much private investment capital.*

The thing to *beware of is the introduction of government subsidies into our social insurance systems that are now supported entirely by payroll taxes.* Such subsidies give the appearance of being a painless way to expand greatly the benefits of the program, since *nobody appears to have his pocketbook tapped therefor, whereas increases in payroll taxes are easily discernible and accordingly, subject to taxpayer resistance.*

APPENDIX IV

IS MEDICARE WITHIN CONSTITUTIONAL LIMITATIONS?

A. MEDICARE

1. *Forces* all wage earners to pay so-called "Social Security taxes" on the first dollar earned, including the earnings of children, widows, the tips of waitresses, taxi-cab drivers, etc., etc.
2. *Pays* hospitals on terms set by government a part of the bills of all over 65 years of age, including millions of the aged who are better situated to pay the bills than those being taxed.
3. *Pays* doctor bills on terms set by government from the above taxpayers' funds and $5.30 monthly fees charged those over 65 years of age.

B. INTENTIONS OF THE FOUNDERS (U.S. CONSTITUTION)

1. In selling the United States Constitution the founders wrote 85 papers known as "The *Federalist* Papers." They said in part:

(*a*) Central governments 'have subverted the liberties of the old world'.

(*b*) Speaking about the possibility of the central government usurping power—"It will always be far more easy for the State governments to encroach upon the national authorities than for the national government to encroach upon the State authorities."

(*c*) "The State governments would clearly retain all the rights of sovereignty which they before had, and which were not, by that act exclusively delegated to the United States".

(*d*) ". . . The power of taxation, . . . is the most important authority imposed upon the union." "But it will not follow from this doctrine that acts of the larger society which are not pursuant to its constitutional powers, but which are invasions of the residuary authorities of the smaller societies, will become the supreme law of the land. These will be mere acts of usurpation, and will deserve to be treated as such."

(*e*) "The powers of the central government are as follows:
- (1) Security against foreign dangers
- (2) Regulation of the intercourse of foreign nations

(3) Maintenance of harmony and proper intercourse among states
(4) Certain miscellaneous objects of general utility
(5) Restraints of the states from certain injurious acts
(6) Provisions for giving due efficacy to all these powers"

(f) "It has been urged and echoed that the power 'to lay and collect taxes, duties, imposts and excises, to pay their debts, and provide for the common defense and *general welfare* of the United States', amounts to an unlimited commission to exercise every power which may be alleged to be necessary for the common defense or the *general welfare*. No stronger proof could be given of the distress under which these writers labored for objections and their stooping to such a misconstruction."

(g) Speaking against government impairing the obligation of contracts: "Very properly, therefore, have the convention added this constitutional bulwark in favor of personal security and private rights. The sober people of America are weary of the fluctuating policy which has directed the public councils. They have seen with regret the indignation over the sudden changes and legislative interferences in cases affecting personal rights become jobs in the hands of enterprising and influential speculators, and snares to the more industrious and less informed part of the community."

(h) *Reptitious interference:* "They have seen too that one legislative interference is but the first link of a long chain of repetitions, every subsequent interference being naturally produced by the effects of the preceding."

(i) "The powers delegated by the proposed constitution of the Federal government are few and defined. Those which are to remain in the State are numerous and indefinite. The former will be exercised principally on external objects, as war, peace, negotiations and foreign commerce; with which the last power of taxation will for the most part be connected. The powers reserved to the several states, will extend to all the objects which in the ordinary course of affairs concern the lives, liberties and properties of people, and internal order, and the improvement and prosperity of the state."

2. SUBSEQUENT AMENDMENTS

(a) Immediately thereafter a Bill of Rights (ten amendments) was added which the founders thought necessary to allay the popular fears of central government usurping power and becoming tyrannical. These were limitations upon the power of government i.e., "Congress shall make no law:—". "No person shall be deprived of property, without due process of law."

(b) The Ninth Amendment reads "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."

(c) The Tenth Amendment reads "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

(d) Thomas Jefferson in speaking of the Federalist papers recognized them as explaining authentically the "genuine meaning" of the Constitution. Jefferson also said: "In questions of power, then, let no more be heard of confidence in man, but bind him down from mischief by the chains of the Constitution."

(e) No subsequent amendments even remotely gave any authority to the national government to subsidize and control medical care.

(f) George Washington wrote: "When the transient circumstances and fugitive performances which attended this crisis shall have disappeared, that work will merit the notice of posterity, because in it are candidly and ably discussed the principles of freedom and the topics of government—which will be always interesting to mankind so long as they shall be connected in civil society."

3. THE SUPREME COURT IN WICKARD VS FILBURN SAID:—

"It is hardly lack of due process of law for government to regulate that which it subsidizes."

The case involved a farmer planting 18 acres of wheat to feed his chickens instead of 15 acres as decreed by the Secretary of Agriculture. Other farmers not planting in excess of the acreage decreed by government were subsidized. The farmer was fined and sold out by government although he *personally* sought no subsidy.

4. WHAT DO YOU THINK THE FOUNDERS MEANT?

Appendix V

Per Capita Prepayment Group Practice Plans

(Kaiser-Permanente Type)

The principle of giving special privilege and special subsidies to Kaiser-Permanente type per capita prepayment group practice plans is wrong.

This would be another "foot in the door" operation.

In this legislation this special treatment is euphemistically called Health Maintenance Organizations (HMO) See Section 239 of the Bill.

Kaiser-Permanente type schemes would be paid a year in advance, the excuse being that it would provide an incentive to prevent illness and reduce the total cost of care. HEW says: The provision of a "full range of services from a *single source* in a coordinated, efficient manner" will reduce costs.

It is intended to expand such prepaid care to citizens under 65 years of age.

Once again, the private free choice medical care system which has naturally developed in the United States will be subjected to morally and economically unsound pressures by government intervention. Government payment is the lever.

Advocates of the scheme have used government and labor union pressure to promote it for years. Even then it has not caught on. Only 4% of the total population have voluntarily, without government special subsidy, chosen to obtain service in this manner. Report of the Committee on Ways and Means of the House of Representatives, gives a clue to what will happen. It reads:

"Under this new approach to payment of Health Maintenance Organizations, *there is expected to be a small increase in the first year or two in the amount of payment* by the program. However, if additional beneficiaries enroll in either existing or newly established Health Maintenance Organizations there is a likelihood of cost savings to the program." (Emphasis added) p. 53.

It is a closed panel operation.

"The individuals with respect to whom such payment would be made would receive Medicare-covered services only through the Health Maintenance Organization, except in emergencies. If an enrolled individual received non-emergency care through some other means than the Health Maintenance Organization, he would have to meet the entire expense of such care." ibid p. 53.

SUBSIDY CAMOUFLAGED

"This payment is to be no more than 95% of the estimated amount (with appropriate adjustments to assure actuarial equivalents) that would be payable if such covered Medicare services were furnished outside of the framework of a Health Maintenance Organization." ibid p. 53.

NOT NEW

The scheme is not new—only the direct subsidy through Medicare and Medicaid is new.

1. A committee on the costs of medical care, organized in 1927 made two key recommendations in 1932. One was:

> "Prepared per capita group practice subsidized by the national government." CURRENT HISTORY, August, 1963, p. 77

It was strongly opposed by doctors fearing it would:

> "—transform the doctor into a harrassed, incompetent, salaried bureaucrat—"

2. Wilbur J. Cohen, as Under Secretary of HEW, in 1966 endorsed a book: "Group Practice and Prepayment of Medical Care" financed by "The Commonwealth Fund" through "The Group Health Foundation." From it we learn:

(A) "A final basic in the plan was the *elimination of the fee system.*" ". . . accomplished through a salary arrangement . . ." (GP&P of MC) p. 20

(B) The Farmers Union in 1934 sponsored the Farmers Union Cooperative Hospital Association at Elk City, Oklahoma. ibid p. 22. IT FAILED. (The book doesn't admit this.)

(C) "The U.A.W. . . . under the leadership of Walter Reuther . . . (established) the Community Health Association of Detroit." (A per capita prepaid group plan.) The new organization's executive director was Doctor Fred Mott,

developer of medical programs for the Farm Security Administration, the Province of Saskatchewan (bankrupt)* and the United Mine Workers (sold to government after being in financial trouble)* ibid p. 51–52.

(D) In 1966 the group plans were interested in the Medicare Law feeling it "will be of great assistance." ibid p. 80–81.

(E) Terms considered necessary included: "The management of the entire operation must be tightly integrated and under *centralized policy guidance.*" ibid p. 86.

What Could Be More Centralized Than Labors' Plans Being Subsidized and Forced Into Operation by HEW?

Yet, Under Secretary of HEW, Veneman, in trying to sell this tight control scheme included in the Bill says:

"Public intervention would be reduced rather than increased." (Patient Care 8/15/70 p. 15)

Also, he said recently governmental intervention was guaranteed explaining:

"As long as *we* pay 37%, *we* ought to have some leverage in the system." (MNR 8/31/70 p. 1)

(F) Regular Group Practice Excluded. *Even though regular group practice appears to be eligible*—one better carefully look at who is behind it—who will administer it and the fine print because:

"There are many instances of physicians working in offices under one roof calling themselves groups, but since each manages the affairs of his own office and practices independently and in competition with his associates, their use of the term does not fit our definition." (GP&P of MC p. 89)

(G) Limitations for the physician are cited in the book partly quoted as follows:

(*a*) "*The sacrifices of certain freedoms* . . .their work schedules are made out to conform to an established pattern, office hours cannot be changed without the consent of someone else. They are forced to take care of someone elses patient and allow someone else to take care of theirs at certain times. They may be called upon to explain departures from the normal procedures or the need for special equipment. They must integrate their activity with those of the rest of the group." ". . . personality is being submerged . . ."

(*b*) "The need to be tested bothers some of the physicians."

(*c*) ". . . the new physician finds himself running into the established order at every turn."

(*d*) "Sharing control of the patient."

(*e*) "Learning to live with others of diverse interests."

(*f*) "The sacrifice of status in the professional community is a factor not to be dismissed lightly."

(*g*) "Limiting consultants to those of the group."

(*h*) "Physicians income in the group is sometimes the problem." ibid p. 93–96

Also, on page 109 we find a quote:

"Each physician is generally to be considered of equal value to the group."

(H) *Backers:*

"By now it is no shock to learn "the organizational plan of H.I.P. (a K-P type of plan in New York) were underwritten by . . . the Albert and Mary Lasker Foundation and the Rockefeller Foundation.'" ibid p. 33

Lasker and Rockefeller are behind the "compulsory nationalized medical scheme" of U.A.W. now waiting in the wings as the Kennedy Bill.

HEW PROPAGANDIZING

HEW has been working for years to force the use of per capita, salaried, prepaid, group practice and in recent years has become quite obvious in its activities.

For example in October, 1967 it organized a National Conference on Group Practice in Chicago and reported on it in an official publication, Public Service Publication No. 1750 openly boosting how it was promoting "group practice."

(A) "All of us who are participating . . . have a common goal: the promotion of group practice as the optimum method of organizing our health manpower and resources to provide high-quality medical care for our nation's population." p. iii

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*Notes added by AAPS

(B) "In 'A Blueprint for Action,' Doctor Cashman's magnificent summary at the closing, we have concrete . . . proposals that can keep us all busy in the days ahead, not just the federal government . . ."

(C) "Conference objectives (HOW to promote, not whether)." p. 2

(D) "Participation, by invitation of the Secretary, was limited to persons who were in the best position to promote group practice . . ." p. 2

(E) William H. Stewart, M.D., Surgeon General PHS, at the time in a keynote address said:

> "*The record of accomplishment in fostering* the spread of group practice, and especially prepaid group practice, *is not what many of us have hoped* it would be—a record of steady and accelerating growth." "The concept is not a new one;" p. 9

(F) "*The number of people covered* by prepaid group practice plans increased from 3.3 million in 1955 to 4.2 million in 1965—surely not a precipitous rise in a decade . . ." He then went on to say:

> "*First*, there are *legal restraints* which bar progress in a number of states, 17 states still prohibit the formation of consumer sponsored groups, . . ." "*Second*, there is urgent need for sources of organizing initiative. These must be strong enough to overcome overt opposition—" "*Fourth*, there is need for more effective support and stimulation at the national level. *We in the federal government are exploring better ways of using our purchasing power to enhance this movement*—"

The entire report disclosed a clear cut conspiracy to control the nation's patients and doctors. Everyone interested in stopping tyranny should get a copy of this 70 page booklet and understand the nature of the promotion behind this scheme. Finally, these statements are made about *State* Laws:

> "Make advice and technical assistance available in the form of expert staff to support state and local movements in removing obstacles in state laws;" continuing "Explore the desirability of legislation to provide for optional federal chartering of health insurance organizations as a possible means of overcoming State or other existing restrictions" p. 32

KAISER FOUNDATION HEALTH PLAN AND HOSPITALS

The director of the Foundation, Doctor Sidney R. Garfield, writing in the April issue of "Scientific American", admits many things which are quite pertinent to the issue at hand. For example:

(1) "Dramatic advances in medical knowledge and new techniques, combine with soaring demands created by growing public awareness, by hospital and medical insurance and by Medicare and Medicaid, are swamping the system by which medical care is delivered."

(2) "National health insurance, an attractive idea to many Americans, can only make things worse."

(3) "Medicare and Medicaid—equivalence of national health insurance for segments of our population—have largely failed . . ."

(4) "It is folly to believe that compounding this demand by extending health insurance to the entire population will improve matters." "On the contrary, it is certain that further over-taxing of our inadequate medical resources will result in serious deterioration in the quality and availability of services for the sick."

(5) "All of this is not to say that U.S. medicine should change over to the Kaiser-Permanente pattern. On the contrary, freedom of choice is important; we believe the choice of alternative systems, including solo practice, is preferable for both the public and physicians. Any change to prepaid group practice should be evolutionary, not revolutionary."

(6) "We have come to realize that ironically the elimination of the fee has created a new set of problems." "Only after years of costly experience did we discover that the elimination of the fee is practically as much of a barrier to early sick care as the fee itself. The reason is that when we remove the fee we remove the regulator of flow into the system . . ."

(7) "The impact of this demand overloads the system and, since the well and worried-well people are a considerable portion of our entry mix, the usurping of available doctors' time by healthy people actually interferes with the care of the sick.

"The same thing has happened at the broad national level the traditional medical-care delivery system, which has evolved rather loosely over the years sub-

ject to the checks and balances of the open market, is being overwhelmed because of the elimination of personally paid fees through the spread of health insurance, Medicare and Medicaid. This floods the system with a changed entry mix characterized by an increasing proportion of relatively well people." (p. 15–19.).

—"*Scientific American*," April, 1970.

The CHAIRMAN. Any questions?

Senator WILLIAMS. No questions. I just want to thank you for your statement. Perhaps I should explain that the reason that there were so few of us here was that the Senate is in session and there are votes being taken and we are having to relay back and forth. Nevertheless, your statement will be studied by the committee members.

Dr. LEITHART. Thank you for allowing us to appear.

The CHAIRMAN (presiding). I have received a number of letters and wires from various citizens of Louisville urging us to hear what you people have to say. I assure you we will read your testimony.

Dr. SACKETT. Would you like to hear it again.

The CHAIRMAN. I would like to recall for a few moments here Dr. Paul Leithart and his associates. Dr. Leithart, it is only the pressure of having to vote in the Senate on these rollcalls that prevented me from being here. I have read everything you said and I would like to ask you a question or two about your testimony.

Do you really seriously think there is any possibility of Congress repealing medicare? You suggest here that it ought to be repealed. Do you really think there is any possibiilty whatever of that happening?

Dr. LEITHART. I must be candid and say that I do not think there is a great likelihood that it would be repealed, although it should be. I feel that it is an inordinately expensive program and that any extension of it will further produce excessive cost demands, utilization and so forth, and we are totally opposed to any further extension of the program.

The CHAIRMAN. The American Medical Association, as well as your association have ways where you could find information by taking polls, and if you don't take them yourselves you read what the other people's polls are saying, I am sure.

Are your physicians and surgeons generally part of the American Medical Association?

Dr. LEITHART. Yes; although some are not.

The CHAIRMAN. Then would they be familiar with the information that the American Medical Association develops in support of its position or in finding what the people of the country are thinking?

Dr. LEITHART. I think so.

The CHAIRMAN. How do you think the people generally feel about medicare? Do you think they are for it or against it? Suppose we asked them if we should repeal it. What do you think their reaction would be?

Dr. LEITHART. I think that Mr. Average American is at the moment perhaps satisfied with medicare as it is. I see no great overwhelming demand for extension on the part of patients or on the part of the patients of other doctors that I discussed this with.

The CHAIRMAN. I am one of the Senators who voted parallel to the way your group was advocating when you advocated that we should not have compulsory health insurance. But I must say in voting with

you I explained to members of your association and to friends I knew in Louisiana who were associated with the American Medical Association and the State medical society, that I really felt we ought to do something about people who had health problems and were not able to pay for them.

Now, unfortunately, I didn't have much choice in terms of what your people were offering us to vote for. Generally speaking, it looked to me like what you people were doing was standing on a negative position.

I think the day that medicare passed they had some sort of a proposition that they were willing to support which seemed very inadequate when the matter had been an issue before the American public for at least two elections, and when the candidate who was announcing in support of medicare had been elected by the people in a nationwide election. To me it seemed, and I made speeches saying, that these costs were going to be a lot more than anybody would anticipate, and I gave the reasons why. I suggested to this committee that we ought to have high deductibles so that we would not be paying the medical bills that people were well able to pay for themselves. That suggestion prevailed in this committee at one time, and then it lost by about one or two votes. Where were your people at that time?

It seemed to me if we had more support we could have prevailed for that principle.

Dr. Leithart. I believe our organization has testified previously on these things. I might state that at the time of the passage of medicare you mentioned the people in need, and the statistics I recall are that there were about 9 percent of the 65 and older in our population at that time who could not afford to pay for their full medical requirements. It is our feeling that these indigents should be taken care of on a local community basis. We do not feel that because there are 9 percent of the people in the population who need help that the program should, therefore, be extended to the entire population.

The Chairman. Our information was that among the aged that 9-percent figure would be very inadequate. It is far greater than that among the aged. Where did you get your figure that only 9 percent of the aged were in need of help with their medical bills at that time?

Dr. Leithart. I will have to validate that later for you. I would say offhand this was part of a survey taken at that time by a statistician working through several universities, as I recall.

The Chairman. I would like to have you provide that for the record then and we will see who is right or wrong. I am not saying you are right or wrong. I just want to get the facts.*

Dr. Leithart. Yes.

The Chairman. I have heard a lot of people say, and I think you ought to respond to it one way or the other, that doctors generally are getting rich under medicare and they are still not satisfied. Are they getting rich under it or not? Are they making more money now thanks to medicare than they were before?

Dr. Leithart. I think perhaps they are making a little more because the general trend for all society has increased.

Our previous witness this morning, Robert Myers, has some statistics on this included in our appendixes, and he shows the income of the

*At presstime the information requested had not been received by the committee.

average physician since medicare has not gone up more than the percentage of income for the average general population.

The CHAIRMAN. You said Robert Myers said that?

Dr. LEITHART. Yes; that is in appendix III.

The CHAIRMAN. I read your statement and I will ask that the appendix be made a part of the record.[1]

Dr. LEITHART. We would appreciate if you would make all the appendixes and our full statement for the record.

The CHAIRMAN. A doctor from New Orleans, a well-regarded man, came up before the committee and discussed the problems that existed with me and he said that a great number of doctors in Louisiana were charging a lot more than they had been charging before. The best excuse he could give for it was that they felt that they hadn't been for the program anyway, and not having been for it, and having it imposed upon them against their will, they saw no reason why they shouldn't charge as much as they thought they could get. What is you reaction to that?

Dr. LEITHART. I think in any group, professional or otherwise, there will be some who charge excessive fees, unfortunately.

The CHAIRMAN. This fellow was saying it was prevalent right there in New Orleans. That is the biggest city in my State.

Dr. LEITHART. I am not aware of overcharging in my area. I am from Columbus, Ohio, there is no problem there. We have a committee of our local county society that handles complaints, and there have been no increased number of complaints regarding charges on the part of physicians over what we had in the past before medicare.

The CHAIRMAN. If I had my way we would have had much higher deductibles than we have now. That would mean people would pay more of their own expenses rather than pay insurance for something that they are able to pay for themselves in many instances. How do you feel about that?

Dr. LEITHART. Personally, I think this is very worthwhile. I might ask Mr. Woolley to comment on this. He is our executive director.

Mr. WOOLLEY. The whole concept of deductibles is sound. It is sounder, of course, to have everybody who can afford to pay for their expenses to pay for them.

The real thrust of this legislation is to extend it to more people who can already pay their own way. Medicare was first advocated on the premise, that people were not able to pay their own way because they were too poor.

Now, the extension of medicare actually turned out to be not something for the poor but for everybody over 65. Now the provisions of this bill are going to extend that in such a way that it will go through a Kaiser permanente type program and enlist, in effect, people below 65 years of age. This will be for people who can pay their way as well as those who cannot.

Now a lot of people will not be able to see when they read the bill how this is a new program and a new foot in the door. But I can assure you that if we could have time to explore it we could make it very clear that this is an extension of that program.

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[1] See p. 366.

The CHAIRMAN. How many more people will be covered by medicare if this bill passes than are covered by it now?

Mr. WOOLLEY. It will be very difficult to estimate how many would be affected, but the device is closed panel salaried group practice. This has been a program of those who believe in compulsory total nationalized medicine. They believe if they can get the principle established of making Government payments to closed panel group practice this will then expand closed panel group practice for those over 65. There have to be as many in the closed panel plan under 65 as there are over 65.

This would pay the panels 95 percent of an estimated fee that would otherwise be paid for medicare on a fee for service basis. This would be estimated. They would pay a year in advance and the assumption is this would cut down on costs and increase efficiency.

The people who are operating closed panel group practice plans understand that there are a lot of questions as to whether they really increase efficiency. The question is whether it doesn't really cut down on the amount of service that is performed.

It would not be a completely private system. A closed panel system is the real thing that we are concerned about in this bill. We think that it is an opening wedge, it is a foot in the door, and it is a real tricky expansion of medicare.

The CHAIRMAN. You, I believe, agree that high deductibles are generally a good thing. Would that tend to eliminate a lot of elective surgery if people had to pay for it?

Mr. WOOLLEY. The higher deductibility the more responsibility will be breathed into the program and the more responsibility that is breathed into it the less costly it will be, the less you will find in the way of this first dollar coverage. You will not find people running to a doctor to get an aspirin, you won't find many running there because they have got a hangnail, and you won't find doctors' offices loaded with patients who really are only worried well people, and thereby usurping the doctor's time who would otherwise be taking care of sick people.

The CHAIRMAN. Will you explain to me just what elective surgery is?

Dr. LEITHART. May I ask Dr. Sackett to comment on it. He is a surgeon.

Dr. SACKETT. Elective surgery is that type of surgery that is not necessary for the life or the real health of the person, like a hernia, a rupture. Certain ones of them I know in my office I tell my patients, both medicare and nonmedicare, "Well, I think you can live with it but if you wish it to be done, if it is bothering you too much, then we can do it." So that sometimes——

The CHAIRMAN. Would the same thing be true if somebody has a large wart on his body that could be removed but didn't have to be? Would that fall into the category of elective surgery?

Dr. SACKETT. Very much so. I urge my patients to leave their warts alone.

The CHAIRMAN. Well, I have known of warts and growths that are not malignant that could be removed. A person's body might be a little more attractive if they were but if it were not they would be about as

*At presstime the information requested had not been received from the committee.

well off except occasionally one of them might get infected if you rubbed it or something of that sort.

Dr. SACKETT. Any cosmetic surgery I would say would be elective.

The CHAIRMAN. Right.

The kind of thing that our committee staff has been concerned about, in that staff report which you quote here, was that we challenged whether we were getting value received for all the money we were paying.

Did you gain that impression from the staff report?

Dr. LEITHART. Yes.

The CHAIRMAN. That to me is the big thing that this committee has been concerned about. It looks to us as though we are not getting what we are paying for.

How many of you have read the book "The Citadel"? It was written by a doctor.

Dr. LEITHART. I recognize it.

The CHAIRMAN. None of you have read it. It sold more than a million copies. It was very critical of medical practice and I felt maybe one of you might have read it.

Mr. WOOLLEY. We have read books that are critical of the medical profession. We have here a book that we recommend everybody read. It is "Medicine and the State" by Lynch and Raphael, Thomas Publishing Co., Springfield, Ill. There are probably at least a dozen or more books on medicine as it relates to Government intervention which have been published, and this one is by far the clearest one. It is divided into two parts. It starts with Germany, Sweden, England, Austria, Russia, and Australia. It points out what the proponents of compulsory medicine said to the legislators, what was said to the medical societies, what the reaction of the medical societies were, how the legislation was finally put into effect. It gives a very clear one, two, three, A, B, C, who was behind it and how it has operated.

In the second half of the book is a comparative analysis of what happened, what happened to the doctor-patient relationship, what happened to the distribution of doctors, what happened to costs, and in every instance the record is clear that Government estimates of costs would be at level A. They always turned out to be not at level A, but level A times some particular factor, always much greater. Utilization is always higher than originally estimated.

Then as the cost goes up it becomes an untenable political situation. Then it becomes politically advantageous to start cutting down and controlling. When the controlling operation starts, attacks are made on doctors and other providers of the service. Then quality goes down, rationing occurs, and the people turn out to have less medical care than they had before.

In Britain right now, they are holding down on the number of doctors who are under contract to the service, and instead of having more doctors they have less. One-third of the graduates of medical schools get out of there to come here or to other countries to escape from socialized medicine. The British are in real trouble with their programs financially and from the standpoint of quality of care.

We are headed for the same thing. I recommend to you people that you get this book and read it because it is objectively written. It tells both sides of the story, it gives the arguments of the interventionists

and it gives the arguments of those who are opposed to intervention, and it gives the facts in an enlightening way.

The CHAIRMAN. I will try to read your book, but I was setting the stage for a question I wanted to ask which concerns me. This is an old book, written by a doctor, and in the course of his book he discusses this situation of physicians, giving people for money a lot of medicine that they really had no need of at all, he discusses one example of this doctor with a lot of people in his waiting room charging back to his wife and saying "Give me a bottle of this." "Give me that." "Just give me anything, and then going back to the waiting room and saying to the patient "take this and you ought to feel better. Take this and sip some of this three times a day," and that sort of thing.

Does that kind of thing happen in medicine? I am not talking about saying, "Just give me anything," but we still have this practice of people being given medicine that they don't really require at all. Do we still have anything like that, people being given pills by a doctor which really have no therapeutic value at all?

Dr. LEITHART. I must honestly say I have practiced medicine in the same community for 20 years and I know of no single instance of any of my colleagues doing this. I myself have never done this. There are, of course, a great variety of ills that the doctor treats, physical and emotional. Perhaps more than 50 percent of the problems we encounter are emotional in the general practice of medicine. But I know of no one who uses seditives, tranquilizers, and so forth unless they feel they are indicated. I really don't think this is an important factor.

You mentioned elective surgery.

The CHAIRMAN. Could I have an answer from your two associates?

Dr. LEITHART. Surely.

The CHAIRMAN. Do you agree with that statement?

Dr. SACKETT. Yes; I believe I would. Where the service is free, I think the patient, is much more dissatisfied if he does not get some type of medicine because it is free and the doctor is almost forced into an untenable position.

In going back into my career, Senator, for a year I spent time at Natchez, Miss., and we took care of many of your indigents from across the river there.

The CHAIRMAN. Well, I am glad you said that. We took care of 10 of yours for every one you took care of for us, but go ahead. [Laughter.]

Dr. SACKETT. And it was commonplace for these people to say "Doctor, aren't you going to give me some medicine?" And if he would try to give them a pill they didn't like it. They wanted the licorice medicine, the liquid medicine. But I think you will find that practice much more prevalent where the service is free.

The CHAIRMAN. Was that your reaction also, Mr. Woolley?

Mr. WOOLLEY. I would say it is obvious that the medical profession is not completely free from people who would take advantage of a patient or a client any more than the legal profession is free from it or that the engineering profession or any other profession, and if you take an individual case of what amounts to fraud or malpractice and then generalize from that you are bound to come out with a false conclusion.

There is one thing that the medical profession does is give what is called a placebo. It is a very common term.

The CHAIRMAN. What is that term?

Mr. WOOLLEY. Placebo, and this is done because of the mental attitude of the individual involved. This is a form of treatment that is carried out when, as a matter of fact, the individual needs some kind of assurance from a mental standpoint, from the standpoint of needing a drug.

The doctors here can explain the placebo approach.

Dr. LEITHART. I don't think placebos are used widely today. I think in the past the little red pill or the little gray pill might have been important in the practice of medicine.

We feel that medical science has improved immeasurably in the last 30 years, and the need for placebos is minimal.

Now, I can envision a postoperative patient, if you want to take just a moment, who seems to need a pain killer longer than we feel necessary, and in that case we may switch from a potent narcotic such as Demerol to perhaps saline injections to see the reaction. This we would call a placebo. But these are used so rarely that I would think it would be very unimportant in any practice.

We might ask Dr. Sackett.

Dr. SACKETT. I think this is very, very true, that probably 25 years ago we used many more placebos than we do today. But with the great advance in the drug industry with the specifics for any single condition, we are less apt and do use far less placebos. You rarely hear the term today in medicine as you did, say, 25 years ago.

The CHAIRMAN. I am led to believe that there are a lot of these combination drugs that are combinations for no other purpose than to charge more money for them. The second or third thing added to the drug has no therapeutic value at all, but is just a good excuse to charge more money. Is that going on or not?

Dr. LEITHART. You are talking about drug houses doing this?

The CHAIRMAN. Yes; I am talking about drugs manufactured with some little something in there that gives them an excuse to say it is, different from the other things that are being ordered, when it really doesn't have any therapeutic value at all. It makes no difference.

Dr. LEITHART. I don't think that it would be a matter of no therapeutic value. I do think some drug companies combine things. Many women who are menopausal will need both hormones and tranquilizers, so the drug houses come out with a combination pill of tranquilizer and hormone. I think this is abominable personally but perhaps other doctors like them because you have a fixed dose, you have a certain amount of tranquilizer with a certain amount of hormone, and I feel if I want to give both I want to adjust the hormone and tranquilizer individually according to the patient's need and so these combination drugs are of no use to me. I think this is true of many doctors and I feel that drug houses are not using as many of these combination drugs. I think it was perhaps done more a few years ago but it is not increasing, to my knowledge.

If I can take one moment, it just occurred to me this matter of placebo has an interesting sidelight which has nothing to do with it but in drug studies a new drug comes along and you want to find out the efficacy of this drug, you take the same looking pill, which is perhaps sugar lactate and use that on half of the patients and use

the real drug on half and study the effects and always you will have a certain percentage of people who do pretty well on the placebo.

Now if we have the same results on the placebo as on the therapeutic drug you probably are going to discard the drug. Here it is used in this fashion. I just wanted to tell you about that.

The CHAIRMAN. I have been concerned because some drug companies were succeeding in selling drugs for at least 40 times the cost of manufacture by selling it with a proprietary name when the drug was in the public domain and anybody could manufacture it. Are you aware that that goes on?

Dr. SACKETT. May I respond to that? I think this may be true, but I think you have to look at it from the other side of the picture. When research is carried on in Government facilities the Government is paying for it in some form, in the form of taxes or general revenue.

But take, for instance, Lederle & Co. a few years ago developed an oral vaccine for polio. They spent $12 million and got not a cent of return on that.

Well, if you are going to encourage these drug houses, they are not subsidized by the Government, they have got to regain that on some other drug that does go over. So they are almost dutybound to keep themselves financially afloat to make these charges.

The CHAIRMAN. Well now, of course, the Government is paying for 70 percent of all this research on drugs to begin with. If these people find a drug at their own expense, they are entitled to a patent on it and they are perfectly privileged then to charge a thousand times the cost of production. You are aware of that, aren't you?

Dr. SACKETT. But their polio vaccine was not accepted by the Government. It was a washout. It was a $12 million loss to one concern.

Dr. LEITHART. If I may respond to this, too, I think when you take the raw product and compare it with the cost of the drug to the consumer over the counter and say there was an increased markup of 4,000 percent, which might happen, you neglect the fact that this raw product required many, many stages in the process of purification.

One drug man answered this in this fashion. He held up his watch and said: "Do you realize what the weight of the main spring, the little hairspring, is in this watch? It is a fraction of an ounce"—and steel at that time was selling so much a ton and the markup on these fine mainsprings was something like almost a million percent, and he was pointing out the fallacy of this markup matter.

There are many processes involved in the final product, and you will have 20 to 30 chemical processes involved in producing a product from the raw material. So this is not all profit. This is manufacturing costs.

The CHAIRMAN. Do you know of any drug company that is advertising to the public that you ought to pay more money for our drug than you can buy it for from other people because we did research in other things?

Dr. LEITHART. No. I think that if we are going to get into the area of generic drugs versus brand names there is something quite new in this area. There is, I am not even aware of the term, "bioavailability." It is a process which may work less well in a certain individual, and FDA is trying to figure out why this is going on. The fact that the chemical analysis is the same, perhaps it did not go through as many refining processes. I am not able to answer.

The CHAIRMAN. Let's just say any one of you had a patient who had a bacterial infection which could be cured if you give him some tetracycline, is there any one of you here who can tell me that Squibb's is better than Pfizer's; that either one of them will have a better effect on the patient.

Dr. LEITHART. I would choose according to the individual patient. I have some patients who, on the plain tetracyclines, will immediately develop diarrhea, whereas, if they are given tetracycline with a product to prevent the development of yeast fungi in the lower part of the body——

The CHAIRMAN. What would that be, what would that be?

Dr. LEITHART. Mysteslin F is a product I use compared to—I didn't mean to advertise the product.

The CHAIRMAN. That is what you are giving him?

Dr. LEITHART. If I have a patient that had trouble, that developed diarrhea on the plain tetracycline, the next time I used it for him I would use a brand product that protected his lower intestine.

The CHAIRMAN. Are you aware that product was ordered off the market because it was found ineffective?

Dr. LEITHART. This is not true, sir.

The CHAIRMAN. That is the information I have.

Dr. LEITHART. That it is off the market?

The CHAIRMAN. Ordered or recommended to be taken off the market; yes.

Dr. LEITHART. This was an action by the FDA. It is not off the market yet, and——

The CHAIRMAN. Who does more testing on that drug, you or the FDA?

Dr. LEITHART. I am sure——

The CHAIRMAN. Isn't that their job?

Dr. LEITHART. I am sure that the manufacturer does quite a bit of testing, and I have——

The CHAIRMAN. I didn't ask you that question. I said you or the FDA. Are you the manufacturer?

Mr. LEITHART. There is no problem there. I don't do any manufacturing but I can judge from clinical results.

The CHAIRMAN. Well, now my impression is that you, as a doctor, are in a position to see what a drug might do or how a patient might respond when he is under your treatment. I would assume that the Food and Drug Administration is trying to get those results with regard to a great number of people. Is that a fair conclusion?

Dr. LEITHART. I would assume so.

The CHAIRMAN. So whose judgment should be superior, yours or theirs, on whether that drug is effective or not?

Dr. LEITHART. I am not certain that their judgment is always superior.

The CHAIRMAN. Well now, is it not true that the patient may have gotten well anyway if you didn't give him anything? Isn't that oftentimes the case?

Dr. LEITHART. It depends on what we are discussing. If it is an emotional problem perhaps it would have subsided.

The CHAIRMAN. I don't think you—are you talking about antibiotics for an emotional problem?

Dr. LEITHART. No; but you said the patient would get well anyway. I think there are many complications of not using antibiotics when they are indicated. For instance, a person having a strep infection, and not receiving it, may end up with glomerulonephritis or rheumatic fever, a variety of conditions, and that they will get well anyway is a very flimsy concept.

The CHAIRMAN. If you are just talking about individual patients, how the individual patient seems to respond to the particular drug that you gave him——

Dr. LEITHART. Yes.

The CHAIRMAN (continuing). Just a single case, isn't it quite possible that, with regard to that individual patient, he may have come down with a high fever the following day no matter what you did, whether you gave him the drug or didn't give him the drug.

Dr. LEITHART. Perhaps Dr. Sackett could respond.

Dr. SACKETT. I would like to interject a little thought here, being a little older than Dr. Leithart. The death rate from pneumonia in the preantibiotic days was 50 percent. Well, every other patient then would get well anyway. But, today, with the use of these antibiotics, the death rate has been cut to, say, 1 or 2 percent.

The CHAIRMAN. I am just talking about how little you know from one or two cases. I sat with a small business committee where doctors wanted us to take severe action against people putting out chlormycetin.

Dr. SACKETT. I believe chlormycetin did come off the market for awhile but it is back on.

The CHAIRMAN. Here was this drug that appeared, in one case in a thousand, to have a very adverse reaction on some patients. But if I have the right drug in mind, we had a doctor come before us and say that he gave his daughter that drug and it killed her. That is an individual case. We had several people who said, that in this particular case, that this drug killed the patient. It didn't help them. It killed them.

Dr. SACKETT. What about the 999 it might have saved?

The CHAIRMAN. That is the point I am getting to. If you are looking at the individual case you have only got one case to talk about. How can you be sure that the drug has the reaction that you are talking about?

All I am saying is that a doctor has a drug salesman come to him and he says here is a drug that is better than anybody else's drug. Now, if he hasn't tried the other man's drug, how does he know it is any better?

Dr. LEITHART. Well, I think that doctors must choose after getting the claims of the drug company. He must study otherwise, find out the chemical composition of other drugs, use the research by experts in this area.

There are many sources available to the doctor to determine which drugs are more efficacious in a particular problem.

The CHAIRMAN. Is any doctor, let's say any doctor in general practice, in a position to really know whether Squibb's products are more efficacious than Pfizer's or whether Pfizer's products are more efficacious than Lederle's products or one or the other of a dozen or so well known-drug manufacturers? Is any doctor in general practice in a position to say: "I can assure you that Pfizer's products are the best.

That they are better than all these other drug manufacturers." Are they in a position to know that?

Dr. SACKETT. Probably not the individual doctor but I might say there is a great wealth of research that is available, if you can compile the results of the individual doctors. Along that line, the American Academy of General Practice, about 5 years ago, has formed a scientific investigation committee where these results will be compiled and it is very possible that we will get more practical results than you will get out of scientific bodies such as the FDA.

The CHAIRMAN. The only point I have in mind is that I just gain the impression that as much as I might like to rely upon an individual doctor, if you are talking in terms of whether one drug is better than somebody else's drug, nobody is going to know unless he has got a laboratory and is in a position to test them and unless he has a sufficient number of people to test them with, he has no basis for comparison.

Do you differ with that or do you agree with that?

Dr. LEITHART. Well, in actual practice, when a particular drug becomes available you learn the merits, demerits, limitations, contraindications, and then you try it. If you get good results, the likelihood would be that you would continue to use it. If it supplants something that was less effective or if it takes care of something that you did not—you were not able adequately to treat previously—and doctors are continuously assaying and evaluating drugs in their practice. It is not a matter of having a single case, it is a matter of continuous cases.

I have sometimes used a drug and dropped it, only to be told by a colleague at a later date, or attend a meeting where a researcher had done some work and I would find that he had—either a group or an individual had found most effective. I would return to it and then find that it, after all, was a good drug. I had not given enough trials or enough cases.

The Chairman. On page 8 of your statement, under the heading of "Individual versus communal responsibilities," it says "Mr. McNerney, head of Blue Cross Association, which is an agency for the Government and obtains large sums of money as a result of Government contracts and who is also chairman of its task force on medicaid and related problems reported." Our experience with Blue Cross was that we had great difficulty finding what was happening to the money that we were paying through Blue Cross in order to see if we were getting our moneys' worth.

It was our experience with that organization that they declined to tell us where the money was going and how much they were paying on the grounds that the doctors were not working for the Government and that they didn't have to give us the information as to how much the doctors were charging their patients. It was only after we had a considerable amount of disagreement with them that we finally compelled them to agree that, in view of the fact that it was the Government that was paying for this health care, we were entitled to know what happened with the money. We gained the impression that Mr. McNerney was strictly on your side.

Mr. WOOLLEY. I think you have——

The CHAIRMAN. At least the Blue Cross were on your side.

Mr. WOOLLEY. You have Mr. McNerney confused with the head of the National Blue Shield Association.

Now, the Blue Cross Association is connected with hospitals and that association would not be paying doctors, generally. As the carrier, they are, generally, paying hospitals.

The CHAIRMAN. I am happy to have that correction. You don't feel the same way about Blue Shield, then, that you feel about Blue Cross.

Mr. WOOLLEY. Blue Shield is a companion organization to a degree with Blue Cross but Blue Cross is connected with hospitals and Blue Shield is connected with the doctors, and there is a considerable difference in different places. They blend together in one State where in another State you will have an entirely different situation.

The CHAIRMAN. Generally speaking, are you generally satisfied with Blue Shield or not?

Mr. WOOLLEY. I would rather that the doctors answer that question because there are questions involved with respect to Blue Shield that are a considerable ways from being what many people think they ought to be.

Dr. SACKETT. I think Blue Shield has—I do not like to use the word "control"—but has a better supervision over doctors' fees than Blue Cross does. They have committees that consult with doctors, have a hearing when the fee is excessive, they may deny a fee, lower a fee. Whereas Blue Cross may not deal with hospitals like Blue Shield does with doctors in the way of fees.

The CHAIRMAN. We asked Blue Shield to tell us how many doctors were being paid $25,000 or more by medicare in 1968, and we had great difficulty getting the information.

Do you see any reason why they have objected to giving us that information?

Dr. SACKETT. I think they finally did. Maybe it presented a bookkeeping problem, I do not know.

The CHAIRMAN. They contended they were working for the doctors and they do not have to release the information unless the doctors authorized it.

Dr. SACKETT. You could find out through income tax statements, could you not?

Mr. WOOLEY. Of course, this begins to be the crux of the problem in this whole area, Senator Long. When an agent of the hospital becomes an agent of the Federal Government, when an agent of the doctors becomes an agent of the Federal Government, then they have a conflict of interest. This conflict of interest is against the interest of the Government and against the interest of the other principals they are serving. This conflict of interest is unsound. They are going to have to be the agent of one or the other.

When the Government has an agent representing one point of view, and that person holds a dual agency, he is in a hopeless position. If you are going to go ahead with Government intervention you might just as well cut it clean and have these boys who think they can play both ends against the middle isolated and out in the open so it is clear they are either the agent of the Government or the agent of another party. They should not try to serve two masters at the same time because it cannot be done.

The CHAIRMAN. Well, you are aware of the fact we heard quite a bit of complaint the other way around, that some of these people are

pretty well dominated by the doctors with the result that they were paying a lot more than they ought to be paying.

Mr. WOOLLEY. I think you would agree it is quite appropriate for a principal to give instructions with respect to policy and operations to his agent, and that it is improper for that agent to turn right around and try to be an agent of another principal who is giving instructions that are contrary to the first principal. I think you would agree with that, wouldn't you?

The CHAIRMAN. Well, it is a little involved, frankly.

Mr. WOOLLEY. But the proposition that you cannot serve two masters is a very clear proposition.

The CHAIRMAN. We are arguing here that Blue Shield was serving the interests of the doctor and not the interests of the Government when it declined to give us that information. It was our judgment that the Government was paying, and the Government had a right to have the information. We are talking about Blue Shield now being the payer.

Mr. WOOLLEY. That is, of course, the basis of our premise, whoever is paying the bill is going to call the tune. If you are going to pay the bill you are going to call the tune. Their reluctance was just an interim proposition. Sooner or later they were going to have to give you that information, and they should have known it. But they bought the idea that somehow or other they were going to have undue influence with the Government, so they would not have to tell what the charges were. Thus they were not playing fair and square with either party.

The CHAIRMAN. Can you tell us what we can do about patients staying in hospitals longer than is necessary. That is one of the problems we are struggling with.

Dr. SACKETT. Make them in some way bear their share of the burden or a higher deductible. I think this will do it. I think the minute the patient has to pay, he becomes very cautious and wary.

I had a patient in the hospital last month who was 85 years of age. I kept going and telling her, "You are going home tomorrow." "Doctor, what about my ear, it is killing me?"

Well, being a general practitioner, I said, "I will have the ear man see you."

Then she was choking to death. Neither the nurse nor I ever saw her choking. She had to stay for that. We had to make sure, run some X-rays, because if she did go home and choked to death you would be in an unhappy legal situation, I know. But if she knew she was paying that bill, she would probably not choke so violently.

The only way I got her out was by saying, "Well, we can't keep you here any more, but we will send you to a nursing home and you are going to have to pay the fee." Well, she went home the next day.

The CHAIRMAN. One thought does occur to me, and that is that this Government, one way or the other, is going to provide health care for people who are not able to pay for it or have great difficulty in paying for it themselves. It will be either a further extension of medicare or something else, and I would hope that your group would not just continue to take the view that they are against anything in this area, so that we are left indefinitely having to choose between one group which wants the Government to pay for everything and

the other group which wants the Government to pay for nothing. I think if that is how it is going to be that eventually the side that is trying to extend governmental activity will prevail.

Personally, my offhand impression would be that where people have considerable medical bills that present them with a serious problem in trying to pay them, that we ought to give them some help. But for those who are well able to pay for their medical expenses, they ought to pay for them.

Mr. WOOLLEY. This, of course, is where you have the difficulty in drawing the line in the first place. The Federal Government is so far removed in actuality from the real causes, of need that this becomes a proposition of the whole theory of Government.

We believe that the local government can do a better job because it is closer to the problem. The discipline of people who are on the spot seeing that there is no waste, and that that government functions properly at the local level, will get a better result.

Now, it is completely wrong, in our judgment, for the Federal Government to move into areas where it is really incapable of adequately doing the job.

Now, the staff report, I think your people did a wonderful job, and I am serious when I say that they should be complimented for doing as well as they did, I understand the limitations under which they function, but if they had gone the whole route, they would have come to the same conclusion that a lot of us came to a long while ago in agriculture.

We used to think that the Department of Agriculture could run everybody's business from Washington. We decided we could not run everybody's business from Washington, so we decided we had better decentralize to the State offices.

When we got out to the State offices, we found we did not know much in the State office, but decided that the place where people knew best what they were talking about was out in the county.

Then when we got to the county, we found the people who really knew best were the people running the farm.

When we finally came full circle we began to find out that all of the wisdom and all of the omnipotence did not rest in a central government place, that it was a lot more important to be on the spot and know what you were talking about there than it was to be someone who could spout a lot of statistics, create confusion and throw up a lot of sand.

We found out that that fellow on the spot knew more about what he was talking about than anybody else, and that is true here.

Now, Mr. Myers was here just before our appearance. Mr. Myers is a fine man, but he had to make estimates of costs, and his estimates of costs, and the estimates of HEW, as your reports show, were way off base.

Why were they way off base? Because assumptions have to be made and then projections with a bale of statistics that is this high.

I was in the Government for 18 years and I understand this as Senator Anderson knows I understand it, and these boys did not know what they were talking about because the assumptions are guesses.

Multiply a whole flock of figures and run them through all the calculating machines that you want to, if you put a bunch of garbage in

you are going to get a bunch of garbage out. If your basic assumption is a guess the answer is a guess.

This is the reason why I am in saying for heavens' sake, get the evidence. These boys have done a good job in this, get the evidence and you will see that this same kind of tomfoolery has occurred in every country, and it is in the nature of intervention itself.

Now, there is not anybody who does not want to have a poor person taken care of who needs it. But this business of projecting more and more Government power in the name of the poor is wrong. That is what we tried to show our testimony. If you will read this medicaid report by the McNerney group, you will see what they are interested in. They are not interested in the poor. They make it crystal-clear that is just the excuse for extending Government power.

If we continue on down this road we will have nobody to blame but ourselves for the wreckage that occurs. There is not any question but what you, as a Senator, know that expenditures of the Federal Government are now out of control. You fellows do not have control, the budget people cannot even tell you for sure just what is being expended, and this whole proposition of spend, spend, spend is either going to have to stop or we will destroy ourselves. I think you fellows know this.

Dr. SACKETT. Mr. Senator, you asked Dr. Leithart in regard to would he see any way that we should repeal medicare. I feel we could not repeal it, but we could modify it.

I, as an individual, am going over in medicare as of November, and I have tried desperately in the last year to find some way to protect myself with private insurance from my own resources, and I just cannot find them. I am going to be forced, even though I do not want to, to go into the medicare program.

As a member of the Florida Legislature, there were many bills that we passed where the prevailing argument or the deciding argument was, "Well, the Federal Government gives us so much." We were not convinced that the program was good, but just because the Federal Government was paying a portion of it this bill was passed just to get that Federal Government money.

I think this is poor policy, poor philosophy, whether on an individual basis or on a legislative basis.

The CHAIRMAN. I would just say, gentlemen, that I am looking for answers. I appreciate your testimony here today.

Dr. SACKETT. I think you were given the answers before you introduced the program, the medicare program. We in medicine said the costs were going to far exceed what you foresaw, and I think we were more near right that you were.

The CHAIRMAN. Well, I voted the same way for a great number of years until I found myself in the minority, and after I found myself in the minority, I concluded we had better try to make it the best bill that we could because it was going to become law whether I voted for it or not.

When you come here now and you tell me that the answer is just repeal the program, I will tell you that that is not going to muster a majority of votes.

Dr. SACKETT. But you could modify it, could you not, in some way? At least, you consider bills to give a certain person citizenship.

Couldn't you modify the bill so that I, personally, on an individual basis, could take care of myself after November?

The CHAIRMAN. If you will propose the amendment I will certainly see that it is considered, I will promise you that much.

All I can say about this is that much of what I predicted was going to be wrong with the program has been proved wrong. But I know we are not going to repeal the program, so I am supporting what amendments I can to try to get these costs under control.

Dr. SACKETT. Why compound it by going into this extra per capita closed panel insurance program. To me it is like you have got a hole already, and the way you are going to eradicate this hole is that you are going to dig a deeper hole around it, and this is just not a good thing to me.

The CHAIRMAN. Well, if we can find some way to get a better value received for our money it would seem to this Senator that we ought to consider it. But I am not going to do it in the way you suggest.

Senator Anderson.

Senator ANDERSON. I just wanted to ask one question. Mr. Woolley is here, and he was in the Department of Agriculture when I was there. All through the Southwest there was an attack on me going on, saying, I was a liftwinger, that the whole congressional delegation were leftwingers, to a man.

Did you change your mind on that?

Mr. WOOLLEY. I did not hear what you said.

Senator ANDERSON. You labeled me a leftwinger, you labeled the whole congressional delegation as leftwingers to a man. Do you still have the same opinion?

Mr. WOOLLEY. I think you are probably having reference to your voting record as it appeared in the Americans for Constitutional Action Voting Record.

The Americans for Constitutional Action Voting Record, the first one, I composed it and did the research work in connection with it, and the comments that I have made to anybody have been in relationship to their voting record as it appears in the Congressional Record. That is the only thing I have said.

I think the ACA Voting Record of 1959–60 will stand cross-examination any place, any time, by anybody on a fair basis.

Now, if your philosophy is Government intervention, if this is what you believe, then, of course, your voting record, in the case of the ACA Voting Record was bad. If, on the other hand, you do not believe in Government intervention, then your record looks the other way.

The CHAIRMAN. Well, thank you very much, gentlemen.

Mr. WOOLLEY. Thank you.

The CHAIRMAN. The next witness is Mr. Jorge L. Córdova, who is the Resident Commissioner of Puerto Rico.

STATEMENT OF HON. JORGE L. CÓRDOVA, RESIDENT COMMISSIONER OF PUERTO RICO; ACCOMPANIED BY DR. ERNESTO COLON YORDAN, SECRETARY OF HEALTH OF PUERTO RICO

Mr. CÓRDOVA. Mr. Chairman and members of the committee, I have with me the Secretary of Health of Puerto Rico, Dr. Ernesto Colon Yordan.

In addition to his present position, he was a distinguished practitioner for a great many years in Puerto Rico, a graduate of the University of Maryland Medical School.

I will, however, make a few remarks before I ask Dr. Colon to talk to you about a particular medicaid problem we have in Puerto Rico.

I am the elected representative of 2,700,000 American citizens. We participate fully in the burdens of the social security program. We are as interested as any other American community in the soundness of this system, but we are not now advocating any particular amendments to the system or its abrogation or anything that goes to its fundamentals.

We are merely here to point out certain inequities with respect to Puerto Rico.

In the first place, the Prouty amendment, which you will recall, was legislation enacted in 1966, which authorized the payment of special benefits to citizens who became over 72 between the years 1968 and 1972, and were not insured. That amendment was not made applicable to Puerto Rico, the Virgin Islands, and Guam, although we pay into the trust fund of the social security, the same moneys in the same manner, and in the same measure as the citizens of the several States.

That is an inequity which was obviously inadvertent but which I ask this committee to see is now finally corrected.

It is already a little late because those people who were entitled to these benefits in Puerto Rico have gone without them for almost 3 years, and the program is only going to be in force for a little over 1 year.

I may say that I introduced an amendment to this effect in the House Ways and Means Committee as soon as I took office here in 1969. The House Ways and Means Committee asked for the proper Government reports. They have not been forthcoming yet, and I understand the difficulty is not with the social security people. I understand they recognize the inequity and they favor its correction.

(H.R. 13399 follows:)

91st CONGRESS
1st Session

H. R. 13399

IN THE HOUSE OF REPRESENTATIVES

August 7, 1969

Mr. Córdova introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To provide that the social security benefits provided by the Tax Adjustment Act of 1966 for certain uninsured individuals at age 72 shall apply in the case of residents of the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That the second sentence of section 228 (c) of the Social
4 Security Act (as added by section 302 (a) of the Tax Ad-
5 justment Act of 1966) is amended by striking out "and the
6 District of Columbia" and inserting in lieu thereof ", the Dis-
7 trict of Columbia, the Commonwealth of Puerto Rico, the
8 Virgin Islands, and Guam"

Mr. Córdova. Now, as to medicaid, Puerto Rico has made great strides in providing health services for the people, for a majority of the people, at least, and although these services are far from adequate, we could not have done nearly as much as we have without the help of the Federal programs approved by this committee.

We appreciate the help provided Puerto Rico in the 1967 amendments under this act. However, some of the special provisions applicable to Puerto Rico pose a real dilemma for us. They very properly require Puerto Rico to institute the principle of freedom of choice in the medicaid program by July 1, 1972.

That principle is not yet applicable to Puerto Rico because Puerto Rico was not able to put it into effect immediately. Congress recognized this and postponed until 1972, its effectiveness in Puerto Rico. But, at the same time, a ceiling of $20 million was placed on the Federal contribution to medicaid.

We firmly believe in freedom of choice. We are ready, we are committed, to provide our share, more than our share, toward its costs, and our medical profession is ready and committed to contribute their share, so that our costs will be the lowest in the Nation, as they are now. But the present Federal ceiling would, in effect, make it impossible not only to improve but even to maintain the present inadequate levels, and the present inadequate quality of medical assistance to our poor.

Dr. Colon Yordan, our secretary of health, will explain to you more precisely the nature of the problem and a suggested solution. I thank you.

Dr. Colon Yordan. Mr. Chairman and members of the committee, I would like to begin by expressing the appreciation of the Government of the people of Puerto Rico, to the Senate Finance Committee, and the Department of Health, Education, and Welfare, for recognizing the need of expending to their fellow citizens in Puerto Rico the benefits of health and welfare legislation applicable to our citizens on the mainland.

This wise policy has paid good dividends in terms of material progress, well-being, and, above all, good will both in Puerto Rico and in the United States.

I would like to respectfully bring your attention that the present ceiling of $20 million, the Federal share for Puerto Rico under title XIX, which was established by the 1967 amendments to the Social Security Act—we consider this ceiling at present to be unrealistic because it fails to provide sufficiently effective influence on the quality of medical care for the medically needy people of Puerto Rico.

This fixed amount, because of the progressive increases in medical care costs and the steep rise in the cost of living, to which we can add an increase in the number of eligible population, has not been able to fulfill the congressional intent of continuously upgrading the quality of medical care. It is also unreal as far as the application of the freedom-of-choice provision in 1972.

Our local health appropriation must increase an average of 10 percent yearly just to meet the escalating cost of health care; so that since 1966 to the present, there has been a 40-percent increase that has not been matched by the fixed appropriation of $20 million for the medically needy in Puerto Rico. This increase in unit costs, plus

the application of Federal minimum wages to hospitals in Puerto Rico, by itself must make the ceiling principle subject to revision and reconsideration at present in all fairness to the legislative intention an in the best interests of the health of our medically needy.

The item of salaries alone illustrates our problem and some ways in which we have tried to meet it. Salaries account for 76 percent of all the expenses of medical care. In order to hold these expenses down the professional staff has had very small increases.

These salaries have increased only 13 percent in the last 3 years. On the other hand we have had to avoid by the Fair Labor Standards Act an increase in the minimum wage rate in the medical field. In Puerto Rico the minimum wage is often the prevailing wage. Therefore, any increase in the minimum is an automatic additional expense. This increase has been substantial. In class A positions the increase has been from $1 per hour as of April 1, 1967, to $1.45 as of February 1, 1970, an increase of 45 percent. In class B positions, the increase has been from 90 cents per hour as of January 14, 1967, to $1.35 as of February 1, 1970, an increase of 50 percent. On February 1, 1971, these minimum rates will probably go to the Federal level of $1.60 per hour.

Our Government is deeply concerned with the need of controlling the increasing costs of health care and we are also deeply committed to continue our efforts and contribute the maximum amounts that our limited budget will permit us toward our share of the whole effort of providing the same quality of medical care to the medically needy as that received by the more affluent sector of our society.

Toward this effort, our Governor, cognizant of the pressing health needs of our island and in spite of other very serious needs and demands on our executive branch, has agreed to recommend and actively seek a new supplementary appropriation of $20 million per year for fiscal year 1972 and following, to be exclusively used in upgrading the quality of care for the medically needy. In order to best use this new money in the health economy and meet our minimal health care needs, we respectfully request for that 2 years, the present limiting ceiling be removed, but that the Federal participation be kept the same as the present—50 percent.

The Federal share of the medicaid program is only $20 million at present, with which to provide high quality health care for 1.2 million eligible persons, or the equivalent of $17 per person per year. The equivalent in the United States is $252 per person per year. This amount, the $17 that we receive, amounts to only 6 percent of the share per person that our fellow continental American citizens receive through medicaid.

By having the ceiling removed and reinvesting the total earned moneys, even if only for a restricted period of 2 fiscal years, after which a reevaluation could be made, the maximum Federal share on a 50 percent reimbursement basis would be $60 million. This will be equivalent to only $50 per medically needy person per year, and only 20 percent of the share that the other States are currently receiving. So, if the request be accepted, Puerto Rico's share of Federal funds of title XIX would still be one-fifth of the States' share.

In fiscal year 1971, with a ceiling of $20 million, the Federal share is 28 percent of the total health investment we make for this eligible group of people. If the ceiling be removed and the Federal share increases to $60 million, the Federal share will only be increased to 37 percent of the total investment, a 9-percent increased share of the total burden.

In contemplating the reinvestment of these earned moneys, our main concern will be toward the effective use of controls to stop the spiraling costs of health care by making use of health maintenance options, multidisciplinary prepaid group practices and other new models of delivery of care, some of which are actually being readied for operation in our island.

Puerto Rico Law 56 of 1969 authorizes the Secretary of Health to purchase services for the needy from health service organizations and to experiment with a variety of models in order to achieve the most effective use of our hard-to-get medical dollars. To this we may add the firm commitment of our physicians, stated previously to the members of this committee, to provide services to needy patients at substantially lower fees than those prevailing at present.

We have been, and will continue to emphasize preventive medicine as the center of our health effort. Small municipalities, the smallest political subdivisions in our island, are being organized into service areas instead of individual health units, and the private and Government medical resources are being integrated into a single health effort.

With additional financial help specially devoted to staffing, we can more effectively see our peripheral health centers, where beds have a low occupancy rate, and convert them into long term or intermediate facilities and thus liberate the costly acute care beds in the regional and subregional hospitals.

This in itself will represent a substantial saving in health dollars. Wise use of these moneys will undoubtedly also result in a much needed shift of medical and paramedical personnel from the urban to the almost medically destitute rural or agricultural areas of Puerto Rico. By providing better pay or financial incentives, doctors will relocate in selected areas which are characterized by extreme poverty, with per capita incomes of $350 to $400 per year, and where very limited government medical care is available at present.

We realize that medical care costs are lower in Puerto Rico than in the mainland, and we hope that they so continue, but lack of additional medical services may lead our people to migrate to other areas in the United States where this care is available, but at a higher cost.

Thus Puerto Rico, under the dispositions of title XIX, will be faced with the payment of bills for medical care rendered our island residents while in the States. We have already received such bills in amounts which, until now, we have been unable to honor.

Through investments made by our Government in our medical education system, we have been able to increase our physician population ratio from 1 to 1,660 in 1960 to 1 to 961 in 1969. Out of this number, 1,037 physicians, or 36.4 percent of the total number of physicians in the island, provide services in the Government health system for the medically needy.

Since 1965, in spite of the limitations imposed by the Federal ceiling and the increased demand for services, our joint investment, Commonwealth and Federal, has resulted in striking improvements in some of our health statistics. The birth rate was successfully lowered from 30.1 in 1965 to 24.8 in 1969; the death rate from 6.7 to 6.4. The number of infant deaths were lowered from 3,421 in 1965 to 1,986 in 1969. The infant mortality rate dropped from 43 per 1,000 live births in 1965 to 29.2 in 1969. Maternal deaths diminished from 40 in 1965 to only 12 in 1969—maternal mortality rate thus dropped from 0.5 in 1965 to 0.1 in 1969.

We are proud that we have used local and Federal funds wisely and evidence to that effect is ample and reflects in continuously improving health statistics for our island. With your help, our island will reach a point in which our bare basic medical needs will be met, and stabilized with further improvements in quality. Above all, we will be able to at last retreat from the economic situation that forced the island into a dual system of medical care, one for the poor and another for the private sector.

Aside from general operating funds for the Department of Health, our Government has invested close to $70 million from special revenues toward the accelerated hospital and health center construction program.

In our peripheral health centers, 76 of which are operating in the island for the exclusive use of the medically needed, a total of 1,816,900 patients were seen in outpatient and emergency services in 1965. In the year 1968, only 3 years later, this number increased to 3,893,482, a 114-percent increase in the number of patients served drugs in this short period. Nevertheless, local and Federal contributions did not show a corresponding increase. These figures do not include services rendered at the regional hospitals which I am sure will evidence a similar trend.

If this request which we consider fair and urgent, cannot be fully endorsed by this committee, an alternative to solve our critical health care problems could be considered, such as increasing the ceiling to $35 million effective fiscal year 1971, an act which can be fully justified by the following points some of which were previously pointed out in more detail:

1. The yearly increase in the local appropriations to maintain our standard of health treatment averages 10 percent. From 1966 through 1972 this is an increase of 60 percent. The Federal Government has not shared in this increase.

2. Between 1967 and 1971 the minimum wage for workers in the medical field will have increased by over 60 percent to the Federal level of $1.60 per hour.

3. The number of patients treated by our peripheral health centers has increased by over 11 percent.

4. Further bills are being received by us from the various States for treatment of residents of Puerto Rico who are traveling for from home to get medical treatment. We are receiving more and more of these bills which we have not been able to honor. This medical treatment would have been cheap in Puerto Rico and the patient, in addition to being near home, would not have had the travel expenses.

5. The eligible population has increased as a result of the population growth. This has been compounded by the increase in unemployment which is being experienced in Puerto Rico as well as in the rest of the United States.

6. We are committed to not only improve the quality of existing services but to provide additional services. We cannot do this without greater Federal aid.

7. Finally, the implementation of freedom of choice which is mandatory as of July 1, 1972, will not be possible until this minimum request becomes a reality.

Positive action by this committee will avoid the dreaded possibility that our island may be forced to withdraw from participation in title XIX if fiscal conditions remain as they are at present. This is something that neither you nor we would like to see happen, knowing that such action will lead to stagnation and possible deterioration of our health care system.

I again thank the committee for the privilege of appearing before you, and I respectfully beg that the record be kept open so that we can provide additional data to support our position.

(A prepared statement of Dr. Colon Yordan follows. Hearing continues on p. 404.)

TESTIMONY OF THE SECRETARY OF HEALTH OF PUERTO RICO

Mr. Chairman, committee members, I want to express the appreciation of the government and the people of Puerto Rico to the Senate Finance Committee and the Department of Health, Education and Welfare, for recognizing the need of extending to their fellow citizens in Puerto Rico the benefits of health and welfare legislation applicable to our citizens on the mainland. This wise policy has paid good dividends in terms of material progress, well-being and, above all, good will both in Puerto Rico and in the United States.

Since World War II, Puerto Rico has developed from a state of extreme poverty and hopelessness to one of relative[1] socio-economic well-being and hopefulness. The evidence to this effect is abundant and many factors have contributed to this dramatic change, which is still continuing. Improvement in health standards for the Puerto Rican people has accompanied this change.[2]

An assessment of health conditions in the island today indicates that:

1. There is still a relatively high incidence of certain preventable communicable diseases. These diseases require a continuing program for their full control. T.B., V.D., some enteric diseases, schistosomiasis and other intestinal parasitosis are included on the list. Programs for protection against diptheria, whooping cough, tetanus, polio, measles, and smallpox, must be sustained in order to maintain the present state of control. We also must be on the alert for new knowledge and procedures to deal with other infectious diseases like influenza, dengue and the common cold.

2. We must continue to support environmental health measures for the prevention of further contamination of our soil, water and air, and take remedial measures to solve some of the problems existing in this regard. Population growth, industrialization and movement of people to urban areas are continuously affecting the environment, requiring continuous alertness and action for protection against health hazards.

3. One of our most serious challenges is to provide preventive and curative personal health services of good quality. The government of Puerto Rico, state and local, with the aid of the federal government, has organized a regional system of health services to provide care for approximately 60% of the people which are medically indigent. This system, which will reach a stage of near full development by 1972, includes primary, area, subregional and regional centers for the provision of comprehensive health care services.

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[1] Puerto Rico's per capita income is around 33% of the national average, but higher than that of any Latin American country.

[2] Appendix Tables I and II.

I want to strongly emphasize that the provision of comprehensive health service is our principal concern at the present time. We consider assistance of the federal government essential in order to attain our goals.

Through our governmental health services, personal preventive services are made available to all the population. However, the well-to-do and upper and middle class citizens get most of the preventive services through private medicine. Curative services are also provided to the medically needy (families of 5 with an annual income under $3,000). We estimate that 60% of our families fall in this category.

The services consist of preventive immunization and vaccination, maternal health, infant and child health, diagnosis and treatment of disease, provision of pharmaceuticals, dental services, hospitalization and nursing home care, mental health, and, to a limited extent, rehabilitation. In the dental program the goal is to have 3rd graders in the school system free of untreated cavities. The public water supplies are all fluoridated.

Within our budgetary limitations, we are providing these services at a cost of $34.00 per person per year. Practically all the personnel providing these services are salaried. There is no free choice of physician or hospital. Persons soliciting services may select the primary health center which they prefer. There is a primary health center in each medium sized or small community. In San Juan and larger communities there are several treatment and diagnostic centers.

Community public health programs such as environmental health, communicable diseases control, maternal and child health, constitute part and parcel of the system.

Private health care services are provided by physicians grouped around private hospitals. They are organized as hospital staffs and not as practicing medical groups, although, in many instances, they function as such. There is no prepaid group practice. Many physicians in private practice operate as solo practitioners. About 25% of the Puerto Rican people are covered by some Blue Cross, Blue Shield, or commercial insurance plan and 5% by medicare. Private medical care is slowly adopting some of the concepts of regionalization.

It is estimated that persons utilizing private medicine spend over $150.00 per year.

At the present time, as directed by a recently enacted Puerto Rican law, the department of health is considering possibilities of bringing together the private and public sectors in a single system. Serious difficulties stand in the way of such change. The difference in expenditures, per capita per year of $34.00 in the public and over $150.00 in the private sector; differences in the forms and levels of compensation of physicians who are salaried in the public sector and fee for service in the private; and adherence to a different system such as a relatively rigid regional system in the public sector and a loose or no real organization in the private sector are among the various difficult problems that must be dealt with.

As authorized by law 56, recently enacted by our legislative body, experiments in the delivery of health care services such as the following are at present in the planning or implementation stages:

1. In one municipality the local practicing physicians are being encouraged to organize and function as a group. The health department and municipal government will contract for their services as a group, rather than on a salaried basis.

2. In another municipality, the local physicians are being assisted in organizing as a cooperative. A consumers cooperative will also be organized to contract with the physicians cooperative. The health department would contract with the consumers cooperative for the provision of services to the needy.

3. In a third municipality government will continue to operate the services directly, but the services will be opened to paying patients. Arrangements for the collection of fees by the center physicians as well as others that may practice in the center are being studied.

4. In another municipality a contract will be made with a private non-profit health agency, in this case, a church hospital, to operate governmental services and thus render services to the needy as well as, to paying clients.

Through these and other actions, we are making attempts to integrate the private and public sector in a single health care system. The need to experiment before embarking in a specific scheme cannot be overemphasized.

We feel that the situation in Puerto Rico is of interest not only to the island residents, but to those in the mainland and in other countries as well. The

provision of health care services of good quality to the people at a cost they can afford is a main objective of all health care systems. Already Puerto Rico, through the Development in the public sector of the regional scheme and of the primary health center has made notable contributions in the field of health care administration. The fact that an underdeveloped community can cange in a relatively short period of time of 25 years, has been a stimulating example for other developing countries.

Federal legislation that applies to Puerto Rico should take into account the stage of development that the health services in the island have reached and the special circumstances that characterize our socio-economic structure. The fact that 60% of the population is provided with personal health services through a regional system and that the Government, commonwealth and municipal, with Federal aid, has available only $34.00 per person per year for this service should merit special consideration.

It is regrettable, however, that sometimes the intent of Congress is not entirely fulfilled in the process of implementation of some major laws. Such is the case of title XIX, law 89-97 of 1965, better known as the social security amendments of 1965, as it applies to Puerto Rico.

Puerto Rico was one of the seven States and jurisdictions which initiated a medical assistance program under law 89-97 on January 1, 1966. This was feasible because when the law was enacted, Puerto Rico was already operating a system of comprehensive health care, for all those unable to pay for health services. Charts I and II show some of the achievements in health under this system.

The official policy of the Department of Health, Education, and Welfare in relation to the medical assistance program, under title XIX, is expressed in supplement D (Handbook of Public Assistance Administration), of which I quote from sections D-5140:

"The passage of title XIX marks the beginning of a new era in medical care for low income families. The potential of this title can hardly be over-estimated, as its ultimate goal is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves."

From section D-5143, I quote: *"A basic concept of title XIX is that of equality of medical and remedial care and service."*

After almost five years of operation of this program, I think it is the right time to question whether these goals have been achieved, nationwide. We have not done so in Puerto Rico. The congressional intent of helping low income families in the Nation avail themselves of high quality medical care on an equal basis as those who can afford to pay, has met great obstacles.

The richer States, like California, New York, Michigan, Illinois, etc., have received a disproportionate share of Federal matching funds under this program, just because they have greater resources to match the Federal share. The poorer States have not been able to take advantage, to such an extent as the richer States, of the benefits of this program.

This is the case of Puerto Rico: The island's per capita income is only about one third of the national per capita income. The effort to provide equality of medical care and service is seriously hindered by a ceiling of $20 million placed on the Federal share. This is equivalent to a Federal ceiling of *$17 per person per year*. The original 55% matching formula established in 1966 was reduced to 50% in 1967.

The island has 1.2 million eligible individuals to cover. Local resources are too limited to achieve the high goals of this program, without additional Federal support.

According to Medical World News,[3] 9.5 million persons from 43 States were receiving the benefits of title XIX in 1969, at a cost of $2.4 billion to the Federal Government. *This amounts to $252 per capita, as compared to $17 for Puerto Rico.*

Puerto Rico has re-invested the Federal grant received through this program in the improvement of its health services. Although the Federal ceiling precludes any increase in the Federal share, no matter how much we increase our efforts locally, the appropriations for health by the State government and the municipalities in Puerto Rico have increased from $62 million in 1965-66 to $97.5 million in 1970.

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[3] 10:20 January 24, 1969.

Rising costs and the increase in population make the Federal ceiling unrealistic. The $17 per capita appropriation authorized since 1966, should be readjusted accordingly.

The cost of health insurance in Puerto Rico has followed a trend similar to that in the U.S. mainland. A Blue-Shield type health insurance plan in Puerto Rico (triple S) offered a policy for $15.00 per month for a family of five in 1966. Such a policy, for a low middle class family will cost twice as much now. One of the most important factors for the increase is the application to Puerto Rico, in recent years, of Federal minimum wages for hospital employees.

The Department of Health has some limited experience in the purchase of hospital services from private hospitals under the crippled children's program. Table I shows the rise in hospital rates under such program in Puerto Rico during the last six years.

The 1967 amendments to Law 89–97 make it mandatory for Puerto Rico to provide free choice of physicians, hospitals, dental and pharmaceutical services to all those (1.2 million) beneficiaries under the title XIX program by 1972. Puerto Rico is anxious to implement the free choice provision. This will be another step in our goal for equality of service, in private and public medicine.

We cannot achieve this objective, however, without additional Federal support. With $17 per capita annual Federal share we cannot purchase health insurance for title XIX beneficiaries. The cost of an insurance policy is about $100 per person per year.

We have been trying to keep all our commitments with the Federal Government as stated in our medical assistance plan under title XIX. It is interesting to note that through the implementation of Puerto Rican law 56 of 1969, (appendix A), we will have complied with practically all the recommendations of the evaluation team of the title XIX program which visited Puerto Rico in 1967. Its recommendations were forwarded to Dr. Ellen Winston, ex-Commissioner of Welfare.

We have not been able to comply with the free choice provision, and we have serious doubts that we might be able to do so by 1972 so long as a ceiling of $17 per person in Federal aid continues in force. We respectfully request, that as a first step in tackling this problem, the Federal Government, in recognition of the real needs of Puerto Rico and of the real effort we are making to achieve the national goal, eliminate the ceiling so that we obtain a 50–50% matching on the monies that we can contribute to our program. The national Governors Conference has approved a resolution, requesting that the 20,000,000 ceiling for Puerto Rico be removed. (See table II)

Puerto Rico needs Federal aid to continue developing its health services on an experimental basis and to continue to explore ways of integrating public and private medical care, while retaining the best of the structure and values of both systems.

It is conceivable that experimentation in the organization and delivery of health services in Puerto Rico could be of value to agencies concerned with medical care organization in the mainland.

TABLE 1.—INCREASE IN COSTS OF HOSPITAL SERVICE CONTRACTS BETWEEN DEPARTMENT OF HEALTH AND PRIVATE HOSPITALS—CRIPPLED CHILDREN'S PROGRAM

Private hospitals	1963-64	1964-65	1965-66	1966-67	1967-68	1968-69	1969-70
Hospital de la Concepción	$12.00	$12.00	$15.00	$18.00	$20.00	$20.00	$30.00
Doctor's Hospital	17.00	20.00	22.00	26.00	35.00	38.00	42.00
Hospital Pavía	17.00	20.00	22.00	26.00	35.00	38.00	42.00
Hospital San Jorge	17.00	20.00	22.00	26.00	35.00	38.00	41.00
Professional Hospital	15.65	17.15	17.15	17.15	22.00	26.00	32.00
Instituto Oftálmico	16.30	20.00	20.00	22.00	24.00	30.00	35.00
Hospital Presbiteriano	17.00	20.00	20.00	25.00	29.00	38.00	[1] 43.00
Hospital Bellavista	10.00	12.00	12.00	14.00	20.00	30.00	36.00
Clínica San Rafael	10.83	11.25	13.00	13.00	20.00	29.00	35.80
Clínica Dr. Pila	10.46	11.25	12.25	14.00	18.00	22.91	34.00
Clínica Oriente	10.86	11.25	11.75	13.27	14.50	14.23	
Hospital Asilo de Damas	13.00	17.00	17.00	19.00	23.00		

[1] After 8 days, per diem payment is reduced to $36.

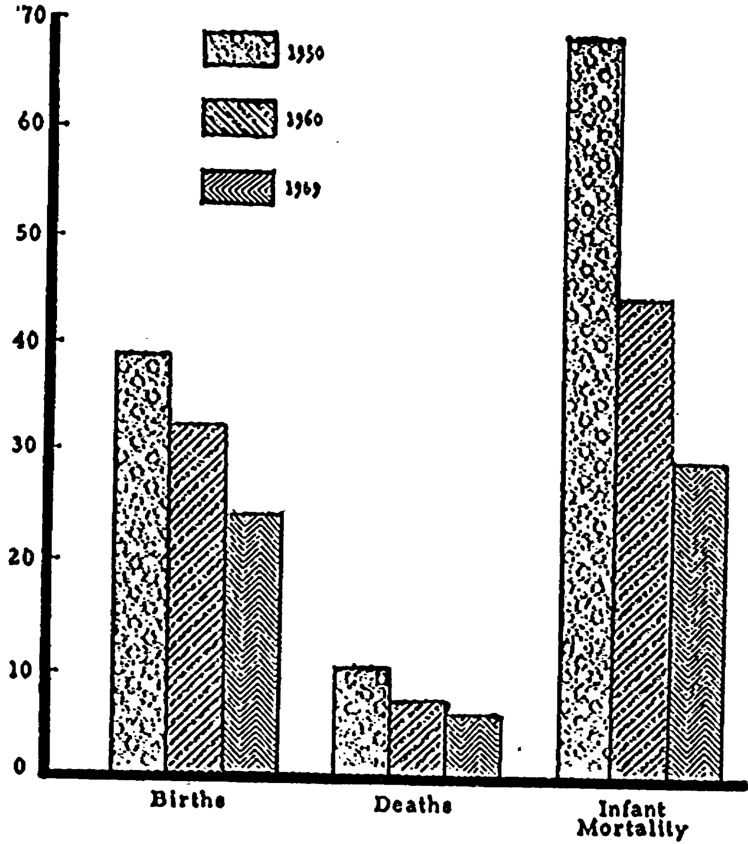
TABLE 2.—DEPARTMENT OF HEALTH OF PUERTO RICO

APPROPRIATIONS FOR HEALTH SERVICES AND AMOUNTS SUBJECT TO FEDERAL MATCHING UNDER TITLE XIX

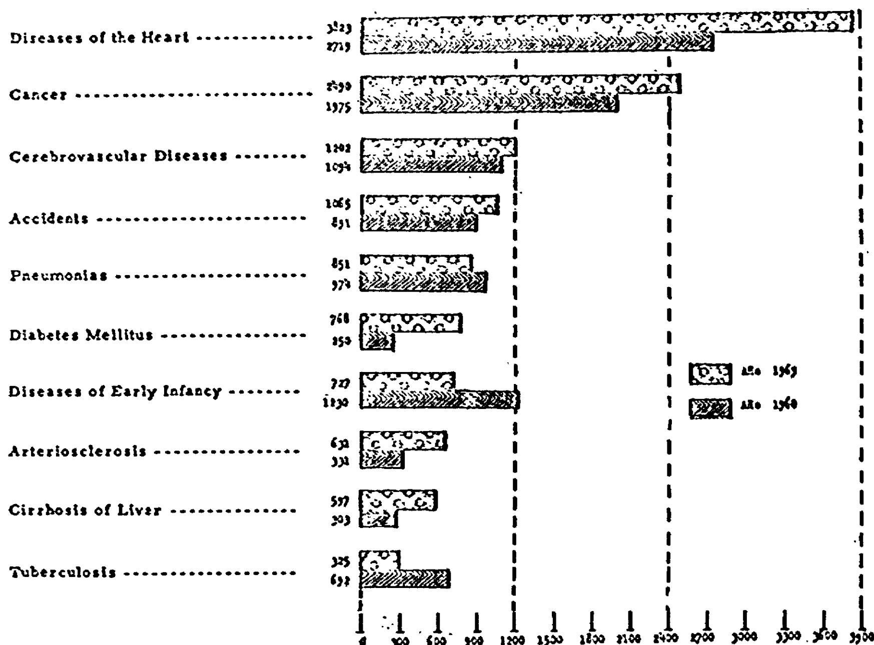
	Amount
Appropriation for Department of Health	$69,661,600
Municipal appropriations	27,800,000
Subtotal	97,461,600
Less:	
Special services:	
Mental health (hospitalization)	4,425,361
Tuberculosis control program (hospitalization)	3,366,361
Subtotal	7,791,722
Amounts already used for Federal matching	5,911,483
Public health and environmental health	5,670,454
Subtotal	19,373,659
Total	78,087,941
Plus:	
Governmental overhead	1,561,759
Depreciation	2,342,638
Subtotal	3,904,397
Reinvestment of title XIX funds	20,000,000
Total	101,992,338
Proportion of expenditures applicable to eligible persons under title XIX (70 percent)	71,394,636
Federal share (50 percent)	35,697,318

CHART I

BIRTH, DEATH AND INFANT MORTALITY RATES*
PUERTO RICO: 1950, 1960, 1969



*Rates:
Birth and death rates per 1,000 population
Infant mortality rate per 1,000 live births



Appendix A

LAW 56

(Approved June 21, 1969)

AN ACT To establish an integrated system of medical-hospital assistance in the Commonwealth of Puerto Rico, within which all persons, independent of their economic conditions, race, color, origin, religion or political creed, may request and receive medical-hospital assistance from any person, agency, organization and institution authorized by law to render such services within the system

STATEMENT OF MOTIVES

Puerto Rico, in proportion to its territorial extension, has public and private resources for the developing, maintenance and conservation of the health of the Puerto Ricans, equivalent in its quantity, variety and quality to similar existing resources in the most advanced countries of the world. In spite of all this, these resources are not integrated into a system capable of offering to every Puerto Rican, comprehensive and adequate health services in quantity, quality, variety and duration. Meanwhile, these resources, continue developing and multiplying through separate roads, in need of a common philosophy of service and in an atmosphere teeming with competition and lacking order and efficiency.

The moment has arrived of offering a formula which will permit our private and public health resources to become a part of a system capable of absorbing

and using the skill and techniques of modern medicine to produce and to place at the disposal of every Puerto Rican its product, comprehensive health services.

The integration of these health services resources into only one system becomes a matter of vital urgency since from and after July 1, 1972, and in accordance with the provision of Section 1902(a)(23) of the Social Security Act of the United States, the Puerto Ricans who are beneficiaries of the health service under Title XIX of this act, must be guaranteed their rights of requesting these services from any person or institution authorized by law to render such services within and without the Commonwealth of Puerto Rico. In order to comply with this provision of law, it is necessary to modify the public policy in regard to the health of the people and to carry out gradually reorganization of the financing, operation and administration of all health resources in Puerto Rico.

BE IT ENACTED BY THE LEGISLATURE OF PUERTO RICO:

Section 1—The Secretary of Health is hereby authorized to use the hospitals, medical centers, health centers, nursing homes, dispensaries, clinics and other health institutions, the property of the Commonwealth and its municipalities, to offer medical-hospital assistance in the same quantity, variety and quality to every person, independent of his economic condition, race, color, origin, religion or political creed.

The Secretary of Health shall establish, with the advice of the Director of the Bureau of the Budget and of the medical, dental and paramedical class of Puerto Rico, the administrative procedures and systems necessary for:

(A) Determining and fixing the reasonable cost of the services of medical-hospital assistance in all health institutions, the property of the Commonwealth of Puerto Rico and its municipalities.

(B) The partial or total payment, as required by each case, of the reasonable cost, as fixed for each health institution, for the services of medical-hospital assistance offered to each person or family whose annual income and other resources results greater than the one established by the Secretaries of Health and Social Services, to determine whether persons or families are eligible to request and receive these services chargeable to public funds, or that they have some kind of health insurance.

Section 2—The Secretary of Health, with the advice of the Secretary of Social Services, shall establish similar standards of application for every person or family, to determine and promulgate the grade of annual income and other economic resources under which a person or family will be certified as eligible to request and receive medical-hospital assistance within and without the health institutions of the Commonwealth and its municipalities, chargeable to public funds. This eligibility certificate shall be transacted through swift and simple administrative procedures, which might best protect the interest of the requesting person or family. An annual review shall be made of the resources under which every person or family obtains the certificate.

Section 3—The Secretary of Health shall establish, with the advice of the Commonwealth Board of Health, a system of medical audit which will permit to evaluate annually, the quantity, variety, utilization and quality of the services of the medical-hospital assistance offered to the public in each health institution.

Section 4—The Secretary of Health, in consultation with the Director of the Bureau of the Budget, shall introduce the administrative procedures for the accounting, deposit and use of the funds collected in each health institution, the property of the Commonwealth and its municipalities, through the charge of the reasonable cost of services offered to persons or families classified under Section 2 of this Act, as not eligible to receive these services chargeable to public funds.

The funds collected under this section shall be used, subject to priorities that the Secretary of Health may establish, for the improvement of the salaries of the personnel and of the health services and facilities.

The Secretary may contract with the municipalities their contribution for the payments of the services given to the residents of the municipality in the Commonwealth hospitals as well as in private hospitals. There shall be accredited as contribution of the municipality a proportional fraction of the sums collected within their territorial limits for services given in hospitals, the property of the Commonwealth, to the users who were able to pay all or part of the service.

Section 5—The medical-hospital services insurance plans and insurance companies engaged in the sale of medical-hospital insurance in the Commonwealth of Puerto Rico, shall be bound to pay to the Commonwealth and to its municipal-

ities, in accordance to procedures as established by the Secretary of Health, the reasonable cost of the services rendered to its insured persons in health institutions the property of the Commonwealth and its municipalities.

Section 6—The State Insurance Fund, as well as any other instrumentality of the Government of the Commonwealth of Puerto Rico and its municipalities, who have established or may establish health services plans for their employees, shall be bound to pay the reasonable cost of the medical-hospital assistance services rendered to their employees in health institutions the property of the Commonwealth and its municipalities.

Section 7—The Secretary of Health is hereby empowered to establish the necessary standards and regulations for the administration and operation of the hospitals and health centers the property of the Commonwealth. He may, through agreements, delegate the operation and administration of the hospitals and health centers, the property of the Commonwealth, in nonprofit associations, corporations of professionals and other groups interested in offering health services to the community.

Section 8—Every physician and every dentist authorized to practice his profession in Puerto Rico and in the private exercise thereof, may charge the reasonable cost of his professional services which he may render to patients in health institutions, the property of the Commonwealth and its municipalities, when said patients are ineligible to receive those services chargeable to the funds of the Commonwealth or municipality.

The services rendered to indigent patients shall be paid by the Commonwealth. The charge for these services, in both cases, shall be made subject to regulations to such effect established by the Secretary of Health. The reasonable cost for these professional services shall be determined by the physician and dentist concerned, in accordance with the Secretary of Health, taking into consideration the usual and prevailing values in the community and the best interest of the patients.

The physicians and dentists who belong to the Medical Staffs of the health institutions, the property of the Commonwealth and its municipalities, may offer these services provided they accept the corresponding appointment under regulations promulgated to such effect by the Secretary of Health, defining the functions, responsibilities and rights of these professionals, in their capacity as members of said medical faculties.

Section 9—The Secretary of Health is hereby authorized to carry out agreement with physicians and dentists in the private practice of their profession, with hospitals, medical centers, health centers, nursing homes, dispensaries, clinics, pharmaceutical service agencies and other private health institutions, so that they may offer hospital-medical assistance to persons or families certified as eligible to receive said assistance chargeable to public funds as herein provided.

Section 10—The medical-hospital assistance service authorized under section 9 of this act, shall be offered in equal conditions and shall be of the same quality as those offered to private patients by persons or institutions which may carry out agreements with the Secretary of Health.

Section 11—Every person or institution who carries out an agreement with the Secretary of Health to offer and render medical-hospital assistance to persons or families eligible to receive them, chargeable to public funds of the Commonwealth and its municipalities, shall comply with the following requirements:

(A) Shall establish an internal system of fiscal audit which permits the Secretary of Health or his representative to verify the reasonable cost of the medical-hospital services to be offered to persons or families eligible to receive such, chargeable to public funds of the Commonwealth and its municipalities.

(B) Shall establish an internal system of medical audit acceptable to the Secretary of Health, and which permits him or his representative to verify, at least once every year, the quantity, variety, duration, utilization and quality of the medical-hospital assistance services rendered to persons or families eligible to receive them chargeable to public funds of the Commonwealth and its municipalities.

(C) He shall annually submit to the Secretary of Health the reports as may be requested in regard with his services and he pledges himself not to request additional payments from his patients for services rendered chargeable to public funds.

(D) He pledges himself to claim from insurance plans of medical-hospital assistance services, the reasonable cost of the services covered by the policy of the person insured with these plans when said insured person is also eligible to

receive the services chargeable to public funds of the Commonwealth and its municipalities. In these cases, the Secretary of Health shall be solely responsible of paying that portion of the reasonable cost of the services not covered by the policy of the insured.

Section 12—The Secretary of Health is hereby authorized to proceed, by stages, in the development of the system herein provided. These stages may be on the basis of population or regional groups or for services in accordance with his criteria, in a definite or experimental manner, in accordance with Act No. 81 of May 31, 1967, but the entire Puerto Rican population shall be covered by said system when the provisions of the Social Security Act, Title XIX, becomes effective July 1, 1972.

Section 13—Any law or provision of law in conflict herewith, are hereby repealed.

Section 14—This act shall take effect July 1, 1969.

Senator WILLIAMS (presiding). I want to thank you for your testimony. The point that you raise as to the extension of the Prouty amendment regarding participation will be considered by the committee.

However, I think this point should be made because it has entered into the previous decision. Benefits under the Prouty amendment were not paid out of the trust fund. They were paid out of the general revenue, as is the Federal matching for medicaid, and in the instance of Puerto Rico, the Government allows all the general revenue to go right on back to Puerto Rico. It does not go into the general fund.

For example, last year, there were $218,622,000 collected in income taxes and excise taxes, all of which reverted back to the island. Those points likewise have to be taken into consideration.

Mr. CÓRDOVA. Senator, if I may make this observation with respect to the Prouty amendment, it is my understanding, and I confirmed this with the Social Security Administration, that the benefits paid under the Prouty amendment are paid partly from the trust fund and partly from general funds of the Treasury.

The difference is this: those people who reach the age of 72 during the years from 1968 to 1972, who had one-quarter or more of coverage, but not enough coverage to be insured, are paid from the trust fund. Those who had no coverage at all are paid from the general fund of the Treasury. Therefore, we are being deprived, some of our citizens are being deprived, of funds which are paid into the trust fund, and they have been deprived for almost 3 years. That is the important point that I want to make.

I do not believe that there is any equitable answer to that, Senator Williams.

The CHAIRMAN (presiding). Does Puerto Rico have a tax base?

Mr. CÓRDOVA. Do we participate?

The CHAIRMAN. Do you pay them?

Mr. CÓRDOVA. We do not pay most of the Federal taxes, that is, the Federal Income Tax Act is not applicable to income earned by residents of Puerto Rico in Puerto Rico.

We do pay, of course, on any income earned outside of Puerto Rico.

Our citizens who have interests abroad in foreign countries or on the Mainland and derive income, of course, pay a Federal tax on that.

In addition, Federal employees in Puerto Rico pay a Federal tax. There are a number of other situations where we pay Federal taxes, but, generally speaking, it can be said we do not pay a Federal income tax.

We do pay a very substantial Puerto Rican income tax which enables us to take care of most of the needs of our government.

I might add that my tax, for example, on my salary as a Member of the House, as Resident Commissioner, which I pay to the Federal Government, must be supplemented by a higher tax which I must pay through the Government of Puerto Rico, that is, my income tax in Puerto Rico is higher than my Federal tax, which shows we are not a tax-haven.

We do offer a tax-haven to certain American industries in order that we may provide employment for our people. This is only limited to a period of 10 years.

The CHAIRMAN. If you collect the income taxes you pay them into the Treasury of the United States?

Mr. CÓRDOVA. We do not; we do not. As distinguished from the Virgin Islands, the Federal taxes that we do pay, such Federal income taxes as we do pay, are paid directly into the Federal Treasury.

The CHAIRMAN. But you do not pay an income tax.

Mr. CÓRDOVO. What is that?

The CHAIRMAN. You do not pay very much, do you?

Mr. CÓRDOVA. Well, as I said, every Federal employee in Puerto Rico pays a Federal income tax. And the Puerto Rican who has income derived from sources outside of the Island of Puerto Rico pays an income tax.

The CHAIRMAN. I mean inside now.

Mr. CÓRDOVA. Income derived from sources within Puerto Rico, a resident of Puerto Rico does not pay Federal income tax on that. He pays a Puerto Rican tax; that is right.

The CHAIRMAN. And, therefore, you do need to have the same amount of money that a person in the United States does.

Mr. CÓRDOVA. We do not need the same help in many programs that a State needs because we have a very substantial fund of local taxes from which to meet our needs.

Of course, our income, per capita income, is very low, and our income taxes, therefore, produce less because there is less to be taxed. Our unemployment is very high and, accordingly, our poverty is very high. So our problems are much greater than those of any State in the Union.

We try to meet them as far as we can with our own local taxation, which is very substantial. I think it is as substantial as any place here. But we need help, which has been provided quite generously by the Federal Government. We are not complaining of the fact that we are not provided help, but we are pointing out one instance where we are paying money, one of the few instances where we pay taxes, where we have not been getting our share, and that is part of the situation in the Prouty amendment.

The CHAIRMAN. You recognize also that you have the same schedules, do you not?

Mr. CÓRDOVA. We have the what?

The CHAIRMAN. Schedules.

Mr. CÓRDOVA. Yes, we do. I mean on social security generally we are covered in the same fashion, and we get the same benefits generally as citizens of the States.

The CHAIRMAN. But you do not pay that money into the Treasury.

Mr. CÓRDOVA. We do not?

The CHAIRMAN. The social security money.

Mr. CÓRDOVA. The social security money, oh, yes, we do; of course, we do. We pay fully the social security tax. Employers and employees pay social security taxes in exactly the same measure as in the States.

The CHAIRMAN. But the chairman of this committee in his State has certain taxes to pay.

Mr. CÓRDOVA. That is right.

The CHAIRMAN. You have some taxes, but you do not pay them to the Federal Treasury, you keep them yourself, do you not?

Mr. CÓRDOVA. You are right. This is chiefly the Federal income tax to which you have referred.

Of course, I must remind the committee, if I may, that we bear other more important burdens of citizenship than the payment of taxes. We have fought in every war in this century. We have been making our contribution of blood. The flower of our youth have been fighting ever since 1917 as part of the Army of the United States.

We bear other burdens, the burden of subsidizing the American Merchant Marine, by paying higher costs for the freight of goods which are coming to and from Puerto Rico because we are subject to the coastwise shipping limitations. We pay a great many of the burdens of American citizens.

Perhaps the only burden which we do not fully share is the burden of taxation, and we do not pay that, we do not share that burden fully, only because we are not as affluent as those who can, who can pay, and that is the same situation in the States. Those who can, pay. Those who cannot, do not pay.

We in Puerto Rico, by and large, cannot pay. Therefore, the Congress, in its wisdom, has seen fit not to tax us in the same manner as those on the mainland who can pay.

The CHAIRMAN. Well, just to clear up some confusion in my mind, let me ask you this: How much would a person pay in Puerto Rico if he made $50,000 a year?

Mr. CÓRDOVA. Yes.

The CHAIRMAN. How much?

Mr. CÓRDOVA. How much in income taxes?

The CHAIRMAN. Yes.

Mr. CÓRDOVA. Well, I can only tell you this: My personal income on my congressional salary, which is $42,500, as you know, last year my tax on that, taking into account my deductions and everything else, a great deal of money I owe and a lot of interest I pay, my Federal tax was perhaps, $9,000.

My Puerto Rican tax on that same income was $13,000 or $14,000.

The reason is, Senator, that in Puerto Rico we do not provide any advantage to married persons. If I were single I would pay less on

the same salary. Because I am married, I have the advantages under the Federal income tax which married couples do. I do not have that advantage in Puerto Rico.

The CHAIRMAN. Am I to understand that the tax that the Commonwealth of Puerto Rico charges on income is actually similar to the tax that the United States charges on income, too?

Mr. CÓRDOVA. It is very similar. As a matter of fact, our statute is copied from the 1939 Federal income tax law. The surtaxes go as high as 90 percent over there, which was the 1939 situation over here.

The CHAIRMAN. Why is it that corporations feel they have such an advantage if they are located in Puerto Rico and put their plants there?

Mr. CÓRDOVA. Because there is an incentive which has been provided by our Government. In order to attract industry and provide employment for our people, because we have tremendous unemployment, we offer industrial plants a 10-year tax exemption if they settle in the metropolitan areas; longer periods, up to a maximum of 17 years, if they settle up in the mountains, where there are very few industries which can afford to settle.

But the highest period of income tax exemption is 17 years. The idea is to induce them to go down, to find out for themselves that they can make money, and many of them find that out and stay there and pay their taxes after their period of tax exemption is over.

The CHAIRMAN. The reason I asked is because it was my privilege to visit Puerto Rico several years ago, and you are doing such a fine job of attracting industry, I thought I would ask the people from the commerce and industry department of the State of Louisiana to go down and see if they could not learn something about how you were doing it? I thought you were doing a fine job of attracting some of the finest blue chip industries of America.

I met quite a few people in Puerto Rico who were very happy that they migrated back. They had gone to New York and found it was not all as nice in New York as they thought. They went there mainly because they could not get a job in Puerto Rico. But when I was there they had returned in order to enjoy all of the tropical pleasant climate that Puerto Rico has especially during the wintertime when it is very cold in New York.

Is that return migration continuing?

Mr. CÓRDOVA. I understand that the flow has about evened out. But, of course, it is very difficult to say because the only statistics that can be kept are the number of people who come into Puerto Rico and the number who leave, and that includes visitors of all types.

The flow is about even, but there is still a migration of the disadvantaged, those who are unskilled and cannot get jobs in Puerto Rico, and who are still coming up to the mainland, mostly to the eastern seaboard, and there is a flow back of those who have acquired skills in the States and can find jobs in these manufacturing industries and feel they are better off coming back to Puerto Rico than staying where they are in the States. That is true.

I might say, Senator, that the industrial program has been successful. It is still being successful. It is our one hope of becoming self-sufficient so that we can fully take care of our poor people and, indeed, reduce poverty to a reasonable level.

I do not believe we will ever eliminate poverty any place in the world but at least we can improve conditions sufficiently so that we will not have to be demanding special treatment.

My own hope is that we can become a State and pay fully our Federal taxes as well as take care of our local taxes. Other people think differently.

I am not speaking as the representative of all people in Puerto Rico in expressing this hope for statehood.

The CHAIRMAN. What is your percentage of unemployment in Puerto Rico among adults today?

Mr. CÓRDOVA. What I might call the official rate is from 11 to 12 percent. But, unfortunately, that is concentrated in the younger element.

The CHAIRMAN. I asked among adults. We have a much higher percentage among younger people than among adults in this country.

Mr. CÓRDOVA. Yes.

The CHAIRMAN. Can you give it to me as among people over 21, for example, in the adult categories?

Mr. CÓRDOVA. I do not have it, Senator, but I can submit it for the record and I will be very happy to. I will get it sometime during the day and submit it for the record.

(The information follows:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., September 23, 1970.

Hon. RUSSELL B. LONG,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: Complying with the request you made when I testified before the Senate Finance Committee last week, the following are the data which I have obtained from official sources in the Government of Puerto Rico:

As to adult unemployment, the statistics available run from 14 to 19 years of age, from 20 to 24, from 25 to 34 and so on. The following is the table of the statistics gathered by the Puerto Rico Department of Labor as of June 1970:

Age and sex	Total labor force	Total unemployed	Percentage unemployed
Males:			
20 to 24	104,000	20,000	19.7
25 to 34	156,000	13,000	8.2
35 to 44	109,000	8,000	7.7
45 to 54	92,000	6,000	6.7
55 to 64	59,000	3,000	4.8
Females:			
20 to 24	52,000	8,000	14.7
25 to 34	76,000	6,000	8.5
35 to 44	53,000	4,000	7.0
45 to 54	29,000	(1)	(1)
55 to 64	12,000	(1)	(1)

[1] Not available.

As you will see, combining all males and females from 20 to 64 and eliminating women from 45 to 64, on which information is not available, the total unemployment figures from the years 20 to 64 inclusive, would be as follows:

Total Labor Force: 702,000.
Total Unemployment: 58,000.
Percentage Unemployed: 8.05.

While 8.05% is a high rate for adult unemployment, statistical experts agree that the real rate is much higher, perhaps as high as 30%, because these statistics reflect only the number of those actively seeking employment, and where unemployment is as high as in Puerto Rico, many people eventually tire of the unsuccessful quest for a non-existent job.

Your other question dealt with the comparability between the income tax rates paid by individuals under the Internal Revenue Code and under the local Puerto Rican Revenue Act. The following table illustrates the comparison for married couples:

Taxable income	Puerto Rico tax	U.S. tax
$2,000	$252.00	$310
$4,000	567.00	682
$6,000	966.00	1,102
$8,000	1,428.00	1,518
$10,000	1,974.00	2,002
$15,000	3,675.00	3,311
$25,000	8,137.50	6,622
$50,000	23,121.00	18,766

As I pointed out in my testimony, the burden on single persons in Puerto Rico would be lower than under the Federal tax, the reason being that married couples in Puerto Rico do not enjoy the special advantage that is granted them under the Federal law, that is, they are treated as a single individual taxpayer and may not split their income.

I trust this is the information you desire, but shall be happy to obtain anything further that may be of interest to you with regard to Puerto Rico unemployment or taxation.

Sincerely,

JORGE L. CÓRDOVA.

The CHAIRMAN. It was generally my thought that on a comparative basis Puerto Rico was doing very well indeed and was making great headway in attracting a lot of industry that some of us would like to see attracted to some of the States we represent.

I am not jealous about the matter, and I am not seeking to hurt Puerto Rico. All I am trying to find out is what is fair.

I must say if I were living in Puerto Rico I think I would vote against statehood for the time being, until I had attracted a few more of those major industries down there.

Mr. CÓRDOVA. Well, I think, you see, we must induce industry to go down. I can think of no greater inducement to attracting the right kind of American capital to Puerto Rico than statehood. There are a great many industrialists who, when they are asked to come down to Puerto Rico, even with all their tax advantages, are asking—

What is going to happen to us after 10 years? Is Puerto Rico going to become another Cuba? What is going to happen to Puerto Rico?

There is no greater security, no greater inducement to industry, than being part of this great country and having assurance of remaining part of this great country.

The CHAIRMAN. Thank you very much for your testimony, gentlemen. We are very pleased to have you here.

Now, the next witness at this morning's session will be Dr. Roy L. Lindahl for the American Dental Association.

Will you proceed, sir, Mr. Lindahl.

STATEMENT OF DR. ROY L. LINDAHL, CHAIRMAN, COUNCIL ON DENTAL CARE PROGRAMS, AMERICAN DENTAL ASSOCIATION; ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER

Dr. LINDAHL. Mr. Chairman and members of the committee, my name is Dr. Roy L. Lindahl of Chapel Hill, N.C. I am here today on behalf of the American Dental Association and am chairman of that organization's Council on Dental Care programs.

In recent months, I also served as a member of the McNerney task force on medicaid and related programs which, as you know, made its final report to the Secretary of Health, Education, and Welfare some 10 weeks ago. With me is Mr. Bernard J. Conway, chief legal officer of the American Dental Association.

DENTAL CARE UNDER TITLE XIX

The question of health care delivery in the United States has become exceptionally pressing in recent years. The situation with regard to changes in the system is fluid and fast-moving. One example of this is the fact that, as we all participate in these present deliberations, we are conscious of the President's announcement that he will present a new family health insurance plan to Congress early in 1971. Since the details of that plan are, so far as we know, not yet settled, it isn't possible to discuss the proposal. We should like, however, to make one comment with respect to the overall concept of the program.

We have every expectation that the administration intends to include dental benefits within the family insurance program. Certainly, exclusion of such benefits would be a serious error to which we would be firmly opposed. Presently, under title XIX, over $200 million is being expended annually for dental care, at least half of this sum being contributed by the Federal Government.

The desperate need for dental care by millions of Americans is well known to members of this committee. A start, however faltering or small, has now been made in meeting that need. It should not be allowed to die. Our association would speculate that one reason the administrative branch might even consider exclusion is because not all members of it have yet learned the lesson of how dental care spending can be focused for greatest impact, efficiency, and economy. One place from which that lesson can be learned is this committee itself.

In 1965, when medicaid was first being considered, an amendment to it was introduced by Senator Ribicoff. Essentially, it would have required States to concentrate available dental care funds on preventive services for children. Senator Ribicoff's amendment was highly commendable. It was accepted by this committee and, indeed, by the entire Senate. Unfortunately, it was eliminated during the subsequent House-Senate conference. The current law, because of its comparability requirements, makes it impossible for States to concentrate their funds in such a way.

The Ribicoff-Finance Committee amendment made sense in 1965 and it still does. We believe that it should be made part of H.R. 17550 and we urge this committee to take that action. I might add that the McNerney task force makes an unequivocal recommendation along this line on pages 40, 41 of its report.

HOSPITAL ADMISSION FOR DENTAL SERVICES UNDER MEDICARE

Under "Part C, miscellaneous and technical amendments," H.R. 17550 contains a provision, section 252, that would remedy a source of confusion that exists under part A of title XVIII as presently written.

Briefly, the provision would permit a dentist to certify the necessity for hospital admission for treatment of a dental condition. Upon such certification and admission the elderly patient's hospital expenses related to such treatment would be covered on the same basis as other medical admissions.

Under existing law, where the hospitalization is for treatment of a noncovered dental procedure, a medicare beneficiary's hospital expenses are covered only if the dentist goes through the cumbersome and unnecessary procedure of arranging with a physician to make the certificaton. Enactment of the provision will bring medicare into conformity in this regard with typical health benefit programs in the private sector including those offered to employees of the Federal Government. It does not, of course, enlarge coverage of dental benefits provided by dentists under the medicare program. The association strongly recommends that the committee support the retention of the provision in H.R. 17550.

Finally, we should like to take note of amendment 851 to H.R. 17550 offered by Senator Bennett. This would create a "professional standards" or peer review system within the States to monitor the cost, quality, and utilization of services offered under titles V, XVIII and XIX of the Social Security Act.

While we concur in the belief that peer review is a desirable component of public and private health care programs, we have serious reservations about the approach taken in amendment 851. One particular defect as far as the dental profession is concerned is the designation of medical societies as the professional standards review organizations with which the Federal Government would contract for such an undertaking.

We believe that the medical profession would readily concede that physicians are not trained to determine the necessity for dental care or appraise its quality. Under these conditions, we do not believe that members of the medical profession would want to take upon themselves the responsibility of invoking or recommending against dentists the sanctions and penalties that would be authorized under the proposed amendment.

While there is a vague provision in section 1155(b)(1) "authorizing" a professional standards review organization—medical society—to utililize the services of "specialists in the various areas of medicine or other types of health care," we do not believe this meets the problem adequately. There are, within dentistry, effective professional review mechanisms already in existence. It fact, the McNerney report singles out the work of the California Dental Service as the type of professional review program that is needed and that should be encouraged.

Dental care under the programs in question should be reviewed by dentists and participating dentists should be judged by their peers. Additionally, dental representation should be required on the review councils provided for in amendment 851.

47-530—70—pt. 2——6

We are pleased to note that since preparation of this testimony, Senator Bennett has advised us that it is not his intention "to require review of dental care by physicians as that would be inappropriate." We assume that language will be included in the amendment to make that intention clear.

Mr. Chairman, this concludes our remarks. We are grateful for this opportunity to present our views. Mr. Conway and I would be glad now to respond to any questions.

The CHAIRMAN. Thank you very much, gentlemen. I think you have made your position very clear and I think that, generally speaking, what you advocate makes good sense.

I have no further questions.

Senator Williams.

Senator WILLIAMS. No further questions.

Dr. LINDAHL. Thank you.

The CHAIRMAN. We will now stand in recess until 3 o'clock this afternoon, in view of the hour of the day, at which time we will hear the remaining witnesses.

(Whereupon, at 1:15 p.m., the committee recessed, to reconvene at 3 p.m., this same day.)

AFTERNOON SESSION

The CHAIRMAN. The committee will come to order.

Our next witness is Dr. Charles E. Jaeckle, vice president for Sociomedical Affairs, American Association of Ophthalmology.

The other members of the committee will be along soon. You may proceed with your statement.

Dr. JAECKLE. Thank you. Someone from your staff approached me to ask if I would let another witness go first. I am ready to proceed as you wish.

The CHAIRMAN. Apparently Mr. Norman has an airline reservation, and we will call Mr. Norman. Mr. C. Robert Norman, president, Indiana Nursing Home Association, accompanied by Albert Kelly, executive director, and Harry T. Latham, Jr., attorney.

STATEMENT OF C. ROBERT NORMAN, PRESIDENT, INDIANA NURSING HOME ASSOCIATION; ACCOMPANIED BY ALBERT KELLY, EXECUTIVE DIRECTOR; AND HARRY T. LATHAM, JR., COUNSEL

Mr. NORMAN. Mr. Chairman, thank you very much for giving us this opportunity to appear.

As we state in our written testimony, we are founding members of the American Nursing Home Association and we continue to be active in that organization.

The American Nursing Home Association will testify in depth as to all aspects of H.R. 17550, and we endorse their testimony.

In the interests of keeping our comments brief, we would like to comment on three specific areas in which Indiana has something we feel will be of value to this committee in its considerations of the indicated sections of H.R. 17550.

Our comments relate to quality of care, quantity of services, and reimbursement.

We endorse the concept of Senator Bennett's amendment No. 651 on peer review in our written testimony.

Since that time, we have considered it more thoroughly and have discussed it with various individuals, including members of the staff of this committee.

We wish the committee to know that we are more convinced than ever that the Bennett amendment will lead to better health care at less cost to the Federal Government, consequently, we are enthusiastic in our endorsement.

In the area of health services, we endorse section 221 because we share the concern of the House Ways and Means Committee, as expressed in its report on H.R. 17550, with regard to "higher costs of medicare, medicaid, maternal and child health care programs where these costs result from duplication or irrational growth of health care facilities."

The Indiana Nursing Home Association has encouraged its membership to participate in the Indiana Health Planning Agency and the regional and local agencies subordinate thereto. We are represented on the State body and on the various regional and county bodies.

Concerning section 222, we would like to briefly outline a concept for an experimental reimbursement project which we feel could well be undertaken in Indiana.

We believe Indiana has certain qualifications which are essential to the potential success of a meaningful experimental program, including:

1. An already existing and thoroughly tested program utilizing a prospective payment plan. The hospitals of Indiana and Blue Cross of Indiana have utilized a prospective payment plan for the past 11 years. It is our understanding that a proposal utilizing prospective rating for an experimental program involving the Indiana hospitals under titles XVIII and XIX is currently being readied for submission to the Secretary and his staff.

2. The Indiana Nursing Home Association will bring to an experimental program a membership which represents approximately 73 percent of the total beds certified for medicare, medicaid, and intermediate care in Indiana.

We would further like to briefly outline what we envision as guidelines to a meaningful demonstration project in Indiana.

The Indiana Nursing Home Industry endorses an experimental program utilizing rates for all services determined in advance of the rendering of services and remaining constant for a specified period of time.

We also would envision certain criteria to which the providers of service would be subject as a condition of participation in an experiment which would include:

1. Active participation in health planning. Indiana's membership welcomes the opportunity to actively participate in the requirements for preplanning and approval for both capital improvements and the expansion of services.

2. Utilization of meaningful principles of pricing and effective guidelines for costs and rate determination.

We are at this time in the process of developing these principles in Indiana.

3. Utilization of a Rate Review Committee. Such a committee would be given power to approve or reject rate requests for all services. The committee would be made up of representatives from industry, from the intermediary, the Government and the consumer public. The committee would review data prepared under the terms of the guidelines and principles outlined above, and would be granted discretionary power of approval or denial of requests. A comparable program has existed in Indiana for the past 11 years and has been very successfully utilized in an advisory capacity to Blue Cross of Indiana in hospital rate determinations.

4. Utilization of a unified rate. All consumers of a specific service would pay the established rate for that service. Thus, medicare, medicaid, private individuals and third-party insurers would pay a single rate, a unified single rate, for comparable service received from a single provider.

Thank you very much, Mr. Chairman. We would be happy to answer any questions.

(The prepared statement of Mr. Norman follows. Hearing continues on p. 419.)

Statement of the Indiana Nursing Home Association

Summary

I. Introduction

(*a*) Names of persons involved on behalf of Indiana Nursing Home Association.

(*b*) Advises that the comments on H.R. 17550 are limited to three sections, namely: Sec. 221, 222 and 225. That Sec. 222 is the principle purpose for appearing and submitting testimony, and that statements concerning Sec. 221 and 235 are brief.

(*c*) That the Nursing Home Association was a founding member of ANHA. That the American Nursing Home Association is scheduled to submit testimony on all health facilities (nursing home) affected sections of the Bill and that INHA indorses the ANHA testimony.

II. Sec. 221. Federal participation for capital expenditures

(*a*) Indorses provision of Bill with the authorized Secretary to withhold or reduce reimbursement for services rendered where a health care facility incurs capital expenditure in excess of $100,000.00 without prior approval of State or local planning agencies.

(*b*) Advises that the Indiana Nursing Home Association membership participates in Indiana Health Facility Planning Agency and regional and local agencies established pursuant to P.L. 89–749.

(*c*) Notes that the enactment of this section provides an indirect franchising concerning which there are potential problems, which problems are more specifically outlined in the American Nursing Home Association statement.

(*d*) Suggests that because of the franchising potential, the Secretary's decisions should be subject to judicial review.

III. Sec. 225. Establishing of incentives for states to emphasize outpatient care for nursing homes

(*a*) Gives qualified indorsement to the section of the Bill which gives 25% medical assistance increase to the states for home health care services. Points out, however, objections raised by Senator Moss of his statement in the Congressional Record, July 21, 1970.

(*b*) Opposes the 90 day limitation for patients in skilled nursing homes and indorses Senator Hartke's statement to the Senate on August 4, 1970, in this regard.

(*c*) Indorses the Moss amendments to the Social Security Act of 1967 which provides for regular State medical review programs and the amendment offered by Senator Bennett to the present Bill, which provides for the establishing within the States of local or area-wide Professional Standards Review Organizations. Both of these being directed toward reducing overutilization of skilled nursing homes. These would be in lieu of the 90 day limitation contained in the section.

(*d*) Gives statistics to show that there is relatively little problem of overutilization in Indiana.

(*e*) Notes that Intermediate Care costs in Indiana are approximately one-third less than Skilled Care costs and that there are about three Intermediate Care beds to one Skilled Care bed in Indiana.

IV. SEC. 222. EXPERIMENTS AND DEMONSTRATION PROJECTS

(*a*) Prime purpose of paper and presentation showing that there already is in existence in Indiana a tested program utilizing prospective payment plan involving Indiana hospitals and Blue Cross of Indiana. Said plan has been in operation for eleven years.

(*b*) That the nursing home industry in Indiana, through the Indiana Nursing Home Association, has a successful working relationship with the State and local government bodies involved with nursing home care as well as the Fiscal Intermediary (Blue Cross of Indiana).

(*c*) That as a demonstration project, the application of the Principles used in hospitals could be adapted to nursing homes.

(d) Summarizes in some detail how such a project in Indiana could develop meaningful data which could well be applied nationally.

TESTIMONY

Mr. Chairman, and members of the Committee. The Indiana Association appreciates this opportunity to appear before this Committee today.

I am C. Robert Norman, Administrator of the Heritage House Convalescent Center, a 100 bed nursing facility in Shelbyville, Indiana. Heritage House is certified for Extended Care, Medicaid and Intermediate Care. I have been in the nursing home field for a number of years and I am currently serving as President of the Indiana Nursing Home Association. I am a member of the Legislative Committee of the American Nursing Home Association.

Accompanying me today are several individuals who assisted in the preparation of this report: Miss Elsie Dreyer, Association Vice President and Chairman of our State Legislative Committee; Sam Gunnerson, CPA, with Turtle Creek Convalescent Centers, and a consultant to our Assoication; Albert Kelly, Executive Director; and Harry T. Latham, Jr., Legal Counsel for the Indiana Nursing Home Association.

The Indiana Nursing Home Association is a non-profit organization representing both proprietary and non-proprietary nursing facilities. Our membership is composed of 244 facilities, representing 14,635 beds. We are also a founding member of the American Nursing Home Association.

The major goals of our Association are to upgrade the quality of nursing home care through educational programs; to deliver the highest quality care at a reasonable cost to the patient; and to maintain an on-going liaison with the Indiana State Welfare Department, the Indiana State Board of Health and the fiscal intermediary for Medicare, Medicaid and Intermediate Care, Indiana Blue Cross.

We are particularly proud of the excellent working relationships that have been established between our Association and the agencies which I just mentioned. I believe each of these organizations would attest to this fact.

H.R. 17550 contains multiple provisions which directly affect the delivery of Health Care in Nursing Facilities. Many of the provisions are excellent and still others we believe need to be deleted or modified. The major portion of our testimony will be directed toward Section 222 with regard to Experiments and Demonstration projects. We will, however, comment briefly on certain other provisions, namely, Sections 221 and 225. The American Nursing Home Association will be presenting detailed testimony before this Committee later this week on the entire Bill and we strongly support that testimony.

SEC. 221. LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

We share the concern of the House Ways and Means Committee as expressed in its Report on H.R. 17550 with regard to the ". . . higher costs (of medicare, medicaid, maternal and child health programs) . . . where these costs result from duplication or irrational growth of health care facilities."

We endorse the provision of Sec. 221 of the Bill which authorizes the secretary to withhold or reduce reimbursement amounts for services rendered under Titles V, XVIII and XIX where health care facilities incur capital expenditure indebtedness in excess of $100,000.00 without the prior approval of State or local planning agencies.

The Indiana Nursing Home Association has encouraged its membership to participate in the Indiana Health Planning Agency (established pursuant to the Public Health Service Act—P.L. 89-749) and the regional and local agencies subordinate thereto. We are represented on the State body and on the various regional and county bodies.

Up to now, the question of enforcement of decisions of those bodies has been the problem. The enactment of this section will go a long way toward solving that problem.

We would add a word of caution, however, in connection with this provision. As is noted in the American Nursing Home Association statement, which is to be presented, it provides, in effect, for an indirect franchise concerning which there are a number of potential problems more specifically set out in said statement. We believe, as ANHA does, that the decisions of the Secretary should be subject to judicial review. Further, insofar as Indiana is concerned, it would be our opinion that any enactment directed toward implementing this provision would have to provide for court review to survive Constitutional considerations.

SEC. 225 ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

Our initial reaction to the first provision of this section which provides financial incentives to the States to encourage Home Health Care Services is that it has merit. However, that reaction is considerably tempered upon consideration of the various ramifications. Senator Moss sums up our doubts best in his statement to the Senate which appears in the Congressional Record of July 21, 1970—We quote, in part as follows:

"Another provision also objectionable is the 25-percent bonus which is given to the State in the event it elects to treat the patient through its home health services, rather than through its nursing home system. * * * The problem here is that over 50 percent of the patients presently on the medicaid roles have no family and no home. What some envisage, then, is purchasing old hotels and buildings and creating artificial homes by the State and then bringing home health services to take advantage of the additional 25-percent bonus in Federal matching funds."

If some means could be devised to eliminate the potential hazards noted by Senator Moss, we feel that provision could be of value.

With regard to that provision of the section which would reduce the Federal medical assistance percentage after 90 days in a skilled nursing home, we must interpose our opposition. The reasons for our opposition are best stated by and contained in a statement by Senator Vance Hartke to the Senate on August 4, 1970, which we quote in part, as follows:

"Medicaid is a prgram for the needy or medically indigent—poor people. If, as Section 225(a) provides, an indigent elderly individual can only receive care in a skilled nursing home for 90 days or care in a mental hospital for 90 to 275 days, or intensive care in a general or tuberculosis hospital for 60 days, he will be at a distinct disadvantage when his allotted time is up. He certainly is not going to be able to pay for his own extended care—and the States will not be able to pay for additional institutional care for him. Evidence of this may be found in projection from the States themselves, on losses they will have to bear if Section 225(a) becomes law.

"It is estimated that New York will lose $105 million, California $20.4 million; and my own State of Indiana estimates a loss of over a millon. Compared to the large losses that will be sustained by New York and California, this loss may seem small, but when one considers the condition of most State budgets these days, it means a great deal in terms of services to older people who have no resources of their own."

According to the Committee Report "These provisions reflect the concern that many patients remain in skilled nursing homes longer than necessary and that as a result program costs are unnecessarily increasing."

We are as opposed to unnecessarily increased costs as is the Ways and Means Committee, but we do not believe that penalizing the patient is the way to combat this problem.

Rather, we would propose the implementation of the Moss amendments of 1967, which calls for the States to set up regular programs of medical review. As far as we can ascertain, very little has been done in this regard, even though these amendments have been part of the law for over two and one-half years.

We note, with interest and approval, the amendments presently before your Committee offered by Senator Bennett. These amendments, as you know, provide, in substance, for the establishment of local or area-wide Professional Standards Review Organizations within the States, made up primarily of physicians who would function as Utilization Review Committees in their respective areas. These Committees would regularly review the level of care of patients and determine that the care given is appropriate.

We are not certain whether this amendment would supplement or supplant the Moss amendment. Under any circumstances, either one or both is much more equitable and fair.

Additionally, we feel that we can state that in Indiana there should be no real concern about the overutilization of skilled nursing homes. In support of this we submit the following statistical information.

1. There are 5,000 certified skilled beds in 99 health facilities. (10 of those facilities are hospital connected, and as result, are not eligible for participation in intermediate care. Of the remaining 89, 63 have dual certification, i.e.: part skilled and part intermediate care.)

2. There are approximately 15,000 intermediate care beds in some 300+ health facilities. (This figure includes the 63 dual certified homes.)

In the dual certified homes, distinct parts are certified pursuant to Federal regulations.

In all instances, at the present time, the patient's physician largely determines the level of care needed and the facilities are governed accordingly. This is particularly effective in the dual certified homes.

One additional fact should be noted in connection with the matter of cost of care in Indiana. That fact is that the cost of intermediate care is approximately one-third less than the cost of skilled care. Further, the Committee will be interested in knowing that in this State we are presently investigating the feasibility of developing a second level of intermediate care, i.e.: lower patient care requirements, particularly personnel-wise. Authorization for this is contained in the promulgated regulations for intermediate care facilities. The implementation of this would result in a further reduction in the overall cost of the medical assistance program.

SEC. 222: EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

As I stated earlier, our prime purpose in presenting our testimony today is to emphasize the need for an alternative method of reimbursement and to outline briefly a concept for an experimental project which we feel could well be undertaken in Indiana. We feel that Indiana has certain qualifications which are essential to the potential success of a meaningful experimental program including:

I. An already existing and thoroughly tested program utilizing a prospective payment plan. The hospitals of Indiana and Blue Cross of Indiana have utilized a prospective payment plan for the past eleven years. It is our understanding that a proposal utilizing prospective rating for an experimental program involving the Indiana Hospitals under Titles XVIII and XIX is currently being readied for submission to the Secretary and his staff.

II. The Indiana Nursing Home Industry represented by its State association has a close and successful working relationship with State and local governmental bodies and the fiscal intermediary.

III. The Indiana Nursing Home Association will bring to an experimental program, a membership which represents approximately 73% of the total beds certified for Medicare, Medicaid and Intermediate Care in Indiana. It is esti-

mated that the total expenditure for health care in nursing homes in Indiana is in excess of 100 million dollars per year. We believe that our membership would provide at least 73% and perhaps more of this total expenditure. It is our feeling that an experiment involving a scope as broad as that outlined above will result in sufficiently valid data to be meaningful

IV. A membership which utilizes a common fiscal intermediary, Blue Cross Hospital Service. The exception to this would be facilities within Indiana which are operated by national chain organizations headquartered outside of Indiana. It is not unrealistic to anticipate that such facilities may also desire to participate in such an experiment.

V. There exists within the framework of the Indiana Nursing Home Association an established framework of committees and liaison structures which will be essential to the implementation, on-going operation, and control of a successful experiment. We have a series of committees which deal with liaison with state and local governmental bodies and our fiscal intermediary. The makeup of these existing groups is such that all interested sections of the association are represented, making possbile effective collection and dissemination of data.

The foregoing are some of the major qualifications which Indiana has that should justify a demonstration project at the earliest possible date.

We would further like to briefly outline what we envision as guidelines to a meaningful demonstration project in Indiana.

I. The Indiana Nursing Home Industry endorses an experimental program utilizing rates for all services determined in advance of the rendering of services and remaining constant for a specified period of time. This is basically what we refer to when we speak of "Prospective Rating."

II. We also would envision certain criteria to which the providers of service would be subject as a condition of participation in an experiment which would include:

A. Active Participation in health planning. Indiana's membership welcomes the opportunity to actively participate in the requirements for preplanning and approval for both capital improvements and the expansion of services. The Nursing Home Industry would expect to have a voice in planning and in turn to subject their plans for growth to approval by the properly authorized planning organizations. Indiana's industry will meet within coming weeks for the purpose of drafting meaningful legislation to be presented to the State Legislature in early 1971. This legislation will be basically along the lines of Section 221, and we are hopeful of the adoption of such legislation irrespective of what the Federal government may do.

B. Utilization of meaningful principles of pricing and effective guidelines for cost and rate determination. We in the Nursing Home Association in Indiana have for some time been aware of a serious need for such guiding principles which have their foundation in generally accepted accounting principles and which can be applied throughout our industry. We are at this time in the process of developing these principles. We are also working closely with our fiscal intermediary for the purpose of developing cost finding reporting procedures which, together with the above guidelines, will provide a common means of determining and reviewing rates.

C. Utilization of a Rate Review Committee. Such a committee would be given powers to approve or reject rate requests for all services. The committee would be made up of representatives from the industry, the fiscal intermediary, government and the consumer public. The committee would review data prepared under terms of the guidelines and principles outlined above and would be granted discretionary power of approval or denial of requests. A comparable program has existed in Indiana for the past 11 years and has been very successfully utilized in an advisory capacity to Blue Cross of Indiana in hospital rate determination.

D. Utilization of a unified rate. All consumers of a specific service would pay the established rate for that service. Thus Medicare, Medicaid, private individuals and third partiy insurors would pay a unified single rate for comparable services received from a single provider. The unified rate would be determined on a provider-by-provider basis. One important aspect of such a unified program will be the elimination of the process of allocation of costs of services and facilities between existing programs. The need for the gamesmanship of such allocations, which have been brought on by inequitable and varied reimbursement programs, would be eliminated and once again, the prime task of facility administration would be the provision of quality health care on the most economical basis feasible.

The CHAIRMAN. Your entire statement is printed in the record.
Thank you very much, sir.
Mr. NORMAN. Thank you.
The CHAIRMAN. We will now hear from Dr. Charles E. Jaeckle, vice president for socio medical affairs of the American Association of Ophthalmology.

STATEMENT OF DR. CHARLES E. JAECKLE, VICE PRESIDENT AND CHAIRMAN OF THE COMMITTEE ON MEDICAL SERVICES AND PREPAYMENT PLANS OF THE AMERICAN ASSOCIATION OF OPHTHALMOLOGY; ACCOMPANIED BY WARREN E. MAGEE, COUNSEL

Dr. JAECKLE. Mr. Chairman, I am Charles Jaeckle. This is Mr. Warren Magee, legal counsel of the association.

The American Association of Opthalmology supports the present provisions of title XVIII as they concern eye patients. We are concerned about amendment No. 756 to H.R. 17550. We are concerned with the subtitle of the new section on page 59, "Coverage of Dental Care, Eye Care, Dentures, Eyeglasses, and Hearing Aids," which is misleading. It erroneously suggests that eye care is not already covered. The act now provides a very good coverage for eye patients.

The essential services are covered including physicians' services, not only in ophthalmology, but in all branches of medicine, both medical and surgical services, and all the ancillary services, and the prosthetic device—that replaces the lens which is removed in cataract surgery—the special form of eyeglasses. The artificial eye prosthesis is also covered.

There are exclusions relevant to eye patients. There are four general exclusions and three special exclusions; namely, eyeglasses which do not replace an internal organ; eye examinations for the purpose of prescribing, fitting or changing eyeglasses—which physicians do not perform—and the procedures performed during the course of any eye examination to determine the refractive state of the eyes.

Only the last is frequently essential to the diagnosis and the treatment of disease or injury.

Removal of the exclusion of procedures performed to determine the refractive state of the eyes would have an effect on medicare patients' expenditures and on medicare's cost.

The medical procedure to determine the refractive state is not a service entity but is performed in the course of diagnostic examination. Removal of this exclusion would have no effect on medical care delivered. The refractive procedure, when required, represents about 20 percent of the service value of a comprehensive diagnostic examination, the average fee for which is $20.

The exclusion amounts to about $4. If medicare were to cover this, the patient would have only a small saving. The aggregate, however, represents a large sum. If one-half of the 20 million approximately insured seek diagnostic examination that covers this, the added costs due to coverage of the refractive portion of that examination in the physician's office would be of the order of $40 million.

"Removal of the exclusion of eye examination for the purpose of prescribing eyeglasses," coupled with the proposal in amendment 756

to cover the services of optometrists would add a supplemental benefit not a part of medical care.

It would not reduce the expenditures for physicians' services. The optometrist does not perform diagnostic examination. The Secretary of Health, Education, and Welfare reported to the Congress:

> Optometrists are not qualified by virtue of training, background, or license to detect or diagnose ocular disease or ocular manifestations of systemic disease. Thus optometrists are not qualified to provide complete eye examination for elderly patients who have a high incidence of eye disease.

The Secretary identified optometric services as essentially refractions, and he also said:

> If optometrists were to provide these services to the elderly in independent practice, the elderly still would not receive the high quality diagnostic examination for ocular disease which would be provided by a medical eye specialist.

Testimony of the American Optometric Association before the House Committee on Ways and Means last October gave the cost of optometric examination as $15 to $30. The record states a cost per patient served of $28.82. If 5 million persons availed themselves of this service, the costs would be $144,100,000 for refractions.

Section 226(b) of amendment 756 would change the definition of physician to make that word include a group of nonphysicians, persons not licensed to practice medicine and surgery; namely, optometrists. Thus, coverage would be provided for nonmedical procedures for the purpose of prescribing eyeglasses, in addition to the existing coverage for diagnostic and treatment services of physicians.

Patients would be offered nonphysician services but under the guise of physician services.

There is inherent danger to the public in a program which simultaneously offers coverage for the services of a physician and apparently alternatively, as if an equivalent benefit, different but apparently similar services by nonphysician practitioners.

In prescribing the lenses the optometrist performs no diagnostic or therapeutic procedure. The essence of optometry is that the optometrist is not a physician. It is imperative that the public not be confused about this identity. To identify the optometrist as a physician is to compound the public confusion.

The proposed amendment in section 226, page 61, lines 20–24, implies that the optometrist is engaged in a diagnosis of eye diseases, an area in which the former Secretary of HEW pointed out that optometrists are not qualified.

Were the Congress desirous of providing coverage for the services of nonphysicians, this should be specifically stated, rather than to introduce a confusing and artificial definition of the word "physician."

Then Secretary Wilbur Cohn reported to the Congress that such provision would, "to some extent, compromise the quality of care provided by medicare."

Virtually everyone over 65 years of age requires eyeglasses, and almost invariably multifocal lenses.

The U.S. Public Health Service estimated for the Mississippi State Board of Health Comprehensive Planning an eyeglass cost of $43.25. We estimate a national average of $50.

If only 5 million, about one-fourth of those insured, were examined or refracted in a year, and half of these utilized eyeglass coverage, the

estimated annual cost for eyeglasses alone would be $125 million. We believe that the addition of this benefit would artificially stimulate utilization.

If the utilization were doubled, the cost for eyeglasses alone for the first 2 years would be a half billion dollars.

The need of the elderly for eyeglasses, being virtually universal, and the need being recurrent, the customary benefits of the casualty principle of insurance are not derived.

The proposed amendment 756 has implications beyond the immediate economic costs. The elderly do not have normal healthy eyes which require only eyeglasses. Most have eyes with disease which require medical examination and diagnosis. Not all will require medical treatment, but if those who require treatment are to receive the treatment which may prevent their going blind, they must first have medical examination and diagnosis.

Retinal disease, cataracts, and glaucoma are common. Glaucoma must be diagnosed early to retain good vision. Lost vision cannot be recovered. The ophthalmologist must decide which patients require treatment and which require watching by the physician.

Because the ophthalmologist is first a physician, his examination may be lifesaving by his diagnosis of hypertension, diabetes, leukemia. cancer, or brain tumor.

Whether the problem is large or small can be determined only after medical examination and diagnosis.

We believe, therefore, that the best interests of the patient and the best interests of the public require that the law continue to provide eye care as it now does. Eyeglassses do not preserve sight. Failure to obtain medical diagnosis can lead to permanent loss of vision and to loss of life.

We recommend that coverage for eyeglasses be considered with caution. We recommend that that part of amendment 756 which amends section 1861(r) of the Social Security Act be not adopted.

I thank you for this opportunity to testify. If there are any questions, I will be glad to respond. We appreciate the opportunity to append further material.

(The prepared statement of Dr. Jaeckle follows. Hearing continues on p. 424.)

STATEMENT OF CHARLES E. JAECKLE, M.D., ON BEHALF OF THE AMERICAN ASSOCIATION OF OPHTHALMOLOGY

Mr. Chairman and members of the Committee, my name is Charles E. Jaeckle. I am a physician, a doctor of medicine, residing and practicing in Defiance, Ohio. I confine my practice to ophthalmology. I am consultant to the United States Public Health Service for the Ophthalmology Manpower Survey. I am here on behalf of the American Association of Ophthalmology, of which I am a vice president and Chairman of the Committee on Medical Services and Prepayment Plans.

Ophthalmology is that medical specialty which is concerned with all diseases and conditions of the visual system—the eyes, the related structures, the ocular muscles, and the nerve pathways to and from the brain. We support the present provisions of Title XVIII of the Social Security Act as they apply to patients with ocular or visual problems and we do not recommend the changes for eye patients proposed by Amendment No. 756 to H.R. 17550. We are concerned that the subtitle of the new section on page 59, "Coverage of Dental Care, Eye Care, Dentures, Eyeglasses, and Hearing Aids", is misleading in that it suggests that Eye Care is not already covered. We note that appropriately there is no refer-

ence to Ear Care. The present Social Security Act now provides almost 100% coverage for Eye Care.

The following services and items necessary for eye patients are covered under Title XVIII, as stipulated in Sec. 1861(s) (1) to (5) and (7) to (9):

1. Physicians' services for the diagnosis and treatment of injuries or disease involving the eye.
2. Certain services and supplies furnished as an incident to the physicians' treatment.
3. Hospital services.
4. Diagnostic services.
5. Physical therapy services.
6. Diagnostic x-ray services.
7. Radiation therapy.
8. Surgical dressings.
9. Ambulance service.
10. The prosthetic device which replaces the lens of the eye (an internal bodily organ which is removed in cataract surgery). This device is the eyeglasses required after cataract surgery. Replacement is also covered.
11. Artificial eye prosthesis and its replacement when required because of a change in the patient's physical condition.

In all areas of medical care Title XVIII beneficiaries are subject to certain exclusions. Some are universally applicable; some are specific for certain areas of medical care. Eye patients are subject to the exclusions listed in Sec. 1862(a). Paragraphs (1), (6), (7), (10) are particularly relevant as they apply to the eye patient. These exclusions are:

1. Services not necessary for the diagnosis or treatment of illness or injury or to improve function of a malformed member.
2. Personal comfort items.
3. Cosmetic surgery (with certain exceptions).
4. Routine physical check-ups of the visual system.
5. Eyeglasses (lenses of which do not replace an internal bodily organ).
6. ". . . eye examinations for the purpose of prescribing, fitting, or changing eyeglasses . . ."
7. ". . . procedures performed (during the course of any eye examination) to determine the refractive state of the eyes . . ."

Only the last 3 items are peculiar to the visual system and only the last a service frequently essential to the diagnosis and treatment of injury or disease.

"Eye examination" merely for the purpose of prescribing, fitting, or changing eyeglasses is essentially an optical service. Such "examinations" are not performed by physicians, who determine the refractive state of the eyes only as an integral part of medical examination.

Sec. 266 of Amendment No. 756 to H.R. 17550 would remove from coverage the last 3 exclusions.

EFFECT OF REMOVAL OF THE EXCLUSION OF PROCEDURES TO DETERMINE THE REFRACTIVE STATE OF THE EYES DURING THE COURSE OF ANY EYE EXAMINATION

The removal of the exclusion of payment for the procedure performed to determine the refractive state of the eyes would have effect on the MEDICARE patient's expenditures and on the financial liability assumed by the Health Insurance Fund. The procedure to determine the refractive state is not a service entity, but is performed in the course of diagnostic ophthalmological examination (a procedure, incidentally, which generally requires the use of medications). Removal of this exclusion would have no effect on medical care delivered. The refractive procedure represents about 20% of the service value of a comprehensive diagnostic examination, the average fee for which is $20. The exclusion amounts to about $4, and is now a cost borne by the beneficiary. If MEDICARE insurance were to cover this procedure, the patient would have 80% of this amount, or $3.20. This is a small saving. The aggregate, however, represenst a large sum. If one-half of the 20,000,000 insured seek comprehensive diagnostic examination in a given year, *the added cost* due to coverage of the *refractive* portion of that examination in the physician's office would be of the order of $40,000,000, of which MEDICARE would pay $32,000,000, and the patients would pay $8,000,000, assuming all had met the deductible. If only one-fourth (5,000,000) availed themselves of this service of diagnostic examination the figures would be $20,000,000, $16,000,000 and $4,000,000 respectively.

EFFECT OF REMOVAL OF EXCLUSION OF "EYE EXAMINATION FOR PRESCRIBING, FITTING, OR CHANGING EYEGLASSES"

Removal of the exclusion of "eye examination for the purpose of prescribing, fitting, or changing eyeglasses", coupled with the proposal in Amendment 756 to cover the services of optometrists, would add a *supplemental* benefit not a part of medical care. It would not reduce the expenditures for physician's services. Any beneficiary, whether he had at some time been under the care of a physician for an eye condition or had not yet consulted a physician, would be eligible to visit an optometrist. The optometrist does not perform diagnostic examination and is neither medically trained nor legally authorized to undertake the responsibility to diagnose disease or injury. The Secretary of Health, Education and Welfare in the 1968 "*Report to the Congress—Independent Practitioners Under Medicare*", stated.

". . . optometrists are not qualified by virtue of training, background, or license to detect or diagnose ocular disease or ocular manifestations of systemic disease. Thus optometrists are *not qualified to provide complete eye examinations for elderly patients*, who have a high incidence of eye disease". (Emphasis added.) (Page 118). And again, "If optometrists were to provide these services ("refractions" and dispensing "mechanical aids to vision") to the elderly in independent practice, *the elderly still would not receive the high quality diagnostic examination for ocular disease* which would be provided by a medical eye specialist." (Emphasis added.) (Page 122.)

According to testimony by V. Eugene McCrary, OD, on behalf of the American Optometric Association, before the House of Representatives Committee on Ways and Means, October 30, 1969, the cost of optometric examination is from $15 to $30. In supplemental information in the record from the same source, the "cost per patient served" was calculated at $28.82. If 5,000,000 insured availed themselves of this service the cost would be $144,100,000 for refractions.

Sec. 226 (b) of Amendments 756 to H.R. 17550 would change the definition of physician to make that word include an additional group of nonphysicians, persons not licensed to practice medicine and surgery, namely optometrists, who do prescribe eyeglasses. Thus coverage would be provided for nonmedical procedures for the purpose of prescribing eyeglasses, in addition to the existing coverage for diagnostic and treatment services of physicians, and patients would be offered the opportunity to use nonphysician services but under the guise of physician services.

There is inherent danger to the public in an insurance program which simultaneously offers coverage for the services of physicians and alternatively, as if equivalent benefit, different but apparently similar services by non-physician practitioners.

The optometrist is at no time functioning as a physician. The optometrist in prescribing lenses is fulfilling his essential function—the measurement of the refractive state and the prescription of lenses apart from medical care. There is no diagnostic or therapeutic procedure. It is for all practical purposes an isolated optical service. When the physician prescribes lenses it is always an incident in the course of medical care, always after diagnosis.

The essence of optometry is that the optometrist is *not* a physician. It is imperative that the public not be confused about this identity. Failure to understand that the optometrist is not a physician can be serious, since he offers his services to the public in lieu of the services of the physician. To identify the optometrist as a physician is to compound the confusion. The public understanding requires that the optometrist be identified as such.

The proposed amendment in Sec. 226, page 61, lines 20-24, properly excludes from reimbursement, any charge an optometrist might make for referral of an individual to a physician, but this clause also implies that the optometrist is engaged in the diagnosis of eye diseases, an area in which the former Secretary of Health, Education and Welfare has already pointed out the optometrist is not qualified.

Were the Congress desirous of providing coverage for the services of nonphysicians, this should be specifically stated, rather than to introduce a confusing and artificial definition of the word "physician". Such a dual coverage, appears to offer a substitute for the services of the physician. The then Secretary of Health, Education and Welfare, Mr. Wilbur Cohen, reported to the Congress on December 28, 1968 that such provision would "to some extent, compromise the quality of care provided by Medicare".

THE EFFECT OF REMOVAL OF EXCLUSION OF EYEGLASSES

If the Congress were to include coverage for eyeglasses, the decision should be taken with full realization of the cost.

Virtually everyone over 65 years of age requires eyeglasses, almost invariably multifocal lenses.

Merrill M. Knopf, M.D., U.S. Public Health Service, made a study of the cost of providing eyeglasses for the Mississippi State Board of Health Comprehensive Health Planning. The Mississippi mean estimate for relatively low power bifocals was $43.25. Using a more representative lens and allowing for cost of living differences we estimate a national average of $50.

If only 5,000,000—about one fourth of those insured under-Medicare were examined or refracted in a year, and half of these utilized this eyeglass coverage, at an estimated average cost of $50.00 per patient, the estimated annual cost for eyeglasses would be $125,000,000, of which Medicare would pay 80%. We believe that the addition of this benefit would artificially stimulate utilization. If the utilization were doubled the cost for eyeglasses alone for the first 2 years would be a half billion dollars. We suggest that even greater caution should be exercised in undertaking coverage for eyeglasses than overage for prescription drugs.

The benefits of insurance are gained substantially by spreading the cost over a population not all of whom will require reimbursement and by spreading the cost over a prolonged period of time. The need of the elderly for eyeglasses being virtually universal and the need being regularly recurrent, these customary insurance benefits are not derived. When such items are insured, administrative costs are added to the basic costs which none can escape.

The proposed Amendments to 756 to extend coverage to optical services have implications beyond the immediate economic costs. It is true the elderly have virtually universal need for eyeglasses, but most also have ocular disease or ocular manifestation of systemic disease. In general the elderly do not have normal healthy eyes which require only eyeglasses. They have eyes with disease which require medical examination and diagnosis. Not all will require medical treatment, but if those who require treatment are to be identified and given the treatment which may prevent their becoming blind, they must first have a medical examination and diagnosis.

Some degree of cataract is found in 80% of patients over 65. Appreciable impairment of vision due to cataract is present in 33%. Glaucoma, a condition of increased pressure in the eye, occurs in 5% of the patients in this age group. Another 5% have borderline elevated pressure and must be kept under medical surveillance so that if glaucoma develops it may be diagnosed early and treated promptly with the prospect of retaining good vision throughout life. When diagnosed in the more advanced stages there is already loss of vision which cannot be recovered. All of these diseases are disabling if advanced. The ophthalmologist must decide which patients require treatment and which require watching by a physician. Because the ophthalmologist is first a physician his examination may be lifesaving by his diagnosis of hypertension, diabetes, leukemia, cancer, or brain tumor.

All of this points to the importance of medical examination and diagnosis and the reassurances that only a physician can give a patient. Whether the problem is large or small can be determined only after the fact of medical examination and diagnosis.

We believe, therefore, that the best interest of the patient and the best interest of the public require that the law continues to provide eye care as it now does—medical care for the eye patient as for patients with other diseases. Eyeglasses do not preserve sight. Failure to obtain medical diagnosis can lead to permanent loss of visions and to loss of life.

We recommend that coverage for eyeglasses be considered with caution. We recommend that that part of Amendment 756 which amends Section 1861(r) of the Social Security Act be not adopted.

The CHAIRMAN. Thank you very much.

Senator Anderson?

Senator ANDERSON. No questions.

The CHAIRMAN. Thank you very much, sir.

Senator ANDERSON. I would just like to say that a glaucoma operation is very pleasant when it works out right.

Dr. JAECKLE. It worked out? We are glad to know that, Senator; yes. With early diagnosis, we usually have the glaucoma patient seeing well today. I began practice when we could not make the diagnosis as early, and we had more blindness and lost eyes.

The CHAIRMAN. Now, our concluding witness for today's session is scheduled to be Mr. Victor Bussie.

STATEMENT OF MICHAEL FREELUND, ASSOCIATE DIRECTOR, NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Mr. FREELUND. Mr. Chairman, I am here in his behalf to express to this committee his profound apologies for his last-minute inability to be here and, by your leave, I should like in his behalf to briefly summarize the testimony and his statement.

The CHAIRMAN. We will do that. I regret Mr. Bussie is not here. He is well known to me. In fact, I regard Mr. Bussie as a good friend. He is an outstanding citizen of Louisiana, as I am sure you are aware.

Mr. FREELUND. Yes, sir.

My name is Michael Freelund. I am associate director of the National Association for Mental Health, of which Mr. Bussie is first vice president.

As you, Mr. Chairman, are probably aware because of your friendship with him, he has devoted many years as a volunteer in the cause of mental health, both in the State of Louisiana and in the national level. He was president of the Louisiana Association for Mental Health in 1965 and 1966.

Our position with respect to the bill under consideration today relates primarily to section 225 which imposes a 1-year limitation in toto during the lifetime of a patient over 65 years of age in a mental hospital. We regard this as an unfair discrimination. No such limitation exists with respect to any other category of disease covered under the law.

Actually when, in 1967, the amendments to the Social Security Act then under consideration were being dealt with, our association, together with others, made very strong suggestions for the elimination of the present limitation which permits only those over 65 the right to be reimbursed for services rendered in mental hospitals. That provision still exists, and now there is a suggestion that an additional discriminatory provision be added; namely, that the amount of compensation or reimbursement that would be made by the Federal program would be limited to 365 days of care under the present law.

This is wholly inexplicable to us, Mr. Chairman, because in every case where there has been an effort made to study this particular issue; namely, the discriminatory provisions regarding reimbursement for care to the mentally ill, the result has been one in opposition to a continuation of such discrimination.

In 1967, as a result of the request of this committee, as well as the House Ways and Means Committee, the Secretary of HEW did conduct a study, and in an interim report stated that:

> Elimination of the age and other limitations with respect to mental illness would be consistent with other title XIX requirements, such as provision of medical services without differentiating on the basis of diagnosis. The present age limitation also tends to exclude those age groups who can best be rehabilitated and returned to the community as constructive useful citizens.

In the recently released report of the task force on medicaid and related programs the following recommendation was made:

In such a flexible approach to care based on patients' needs, an arbitrary limitation on duration of care of patients in mental institutions is inappropriate, and the task force recommends against imposition of any limitation.

We are perfectly aware, and well understand and commend Mr. Chairman the purpose of providing measures that would be incentives for the provision of other alternative means of care. But it is hardly plausible to even suggest that the elimination of care for indigent patients over 65 in institutions for mental diseases would suddenly result in the creation of brand new alternate care facilities. As a matter of fact, we know the contrary is quite the case.

We know that there is a great deal of difficulty in securing adequate financing for the splendid community mental health centers program which gave such promise when first enacted, and that in the years since amounts of money being made available for that program have continued to be reduced in succeeding sessions of the Congress, and thereafter reduced by act of the executive.

If these patients are not going to be reimbursed in State hospitals, we will find ourselves in the ironic situation of States being charged with the responsibility for paying for care at the very time when there is serious consideration being given to means for providing the States with the wherewithal to carry on their business in public institutions through tax return and similar provisions.

All in all, I say to you, Mr. Chairman, and to you, Mr. Anderson, that this is indeed an unfortunate attempt to do something good with the results that may be far, far from good.

Thank you very much.

(The prepared statement of Mr. Bussie follows. Hearing continues on p. 428.)

STATEMENT OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC., BY VICTOR BUSSIE, BATON ROUGE, LA.

Mr. Chairman and Members of the Committee:

My name is Victor Bussie. I am a resident of Baton Rouge, Louisiana, and I am President of the Louisiana AFL-CIO. I am appearing today in behalf of the National Association for Mental Health of which I am Vice President. I have been a citizen volunteer in mental health association work for the past 12 years, and during 1965-1966 I was president of the Louisiana Association for Mental Health, an affiliated Division of NAMH. I deeply appreciate this oportunity of presenting our views before this Committee.

I am quite certain that most of the members of the Committee, including your distinguished Chairman, reside in counties in which there is a Mental Health Association; I am absolutely certain that all of you reside in States in which there is a State Mental Health Association. These are among the more than 800 affiliated Chapters and Divisions of the National Association for Mental Health. We are a volunteer, non-profit, citizens organization with one million members and associated volunteers.

These are the concerned, informed citizens in towns and cities across the country for whom I speak; but more importantly, I speak also for the more than one million patients residing in the hospitals—both public and private—and the uncounted other millions receiving treatment as out-patients.

Mr. Chairman, I am appearing here today to challenge a provision in H.R. 17550 that we feel would be a serious setback for the hard-won gains resulting from efforts made to date to improve the quality of care and treatment for patients in our mental hospitals.

I refer specifically to Section 225 of the proposed bill which places a life-time limit of one year for Federal participation to eligible patients over age 65 receiv-

ing in-patient services in a hospital for mental diseases. Neither of the other two categories referred to under this section, i.e., in-patient services in a general hospital and in-patient services in a skilled nursing home have a similar lifetime limit. An eligible patient's lifetime limit of mental hospital benefits under this provision is fixed at 365 days, after which all Federal support would cease. This is not the case with the other two categories mentioned above.

Such an arbitrary discrimination is completely counter to modern concepts of care for the mentally ill. While we are in complete accord with efforts aimed at developing alternatives to in-patient care in mental hospitals, we cannot accept the apparent rationale that to cut off Federal support after one year would somehow magically produce alternate care facilities to accommodate the mentally ill who are now being provided for under the present law. While it is true that there would be a saving in Federal dollars if this proposal were to take effect, this alone cannot possibly justify the ensuing human suffering by those who would be directly affected by such a reduction in terms of reduced treatment services supported by these medicaid dollars—the mentally ill and their families.

Allow me to explain briefly why the proposal in this legislation to terminate Federal support for this category of patients would be, as I mentioned earlier, a serious setback in terms of the work that has been done during the past few years to provide better treatment for patients receiving care in mental institutions.

1. In 1961 the final report of the Joint Commission on Mental Illness and Health, Action for Mental Health, was published. This report clearly underlined that it had been a historic mistake to make the State alone responsible for public care of its mentally ill residents—relieving local communities and sparing the Federal Government. The report specifically recommended that a share of the cost of state and local mental patient services be borne by the Federal Government.

The partial fruition of this recommendation was realized with the passage of the historic 1965 Social Security Amendments. It was largely through the efforts of the distinguished Chairman of this Committee that the above-mentioned legislation enabled the Federal Government to become a partner in the sharing of the costs of care for indigent patients over age 65 in institutions for mental diseases, and for persons of any age with any type of mental disorder receiving care in a psychiatric ward of a general hospital. Congress intended that the needy mental patient be entitled to obtain high quality care. It is this same category of patient from whom this legislation would seek to arbitrarily withdraw Federal support at the end of one year. This would also result in an added financial burden to the States at a time when revenue sharing is being espoused as necessary and desirable.

2. When Congress was considering the Social Security Amendments of 1967, the National Association for Mental Health urged the Congress to remove the discriminatory provisions existing under Title 19. I refer to those provisions (which are still part of the present law) that limit Federal payment for in-patient hospital services in an institution for mental diseases to patients age 65 or over.

Consequently, both your Committee and the House Committee on Ways and Means directed the Secretary of Health, Education and Welfare to conduct a study on the whole question of modifying the Social Security Act in order to remove these limitations. The interim report that came back to your Committee from the Secretary of HEW in December 1968, stated the following: "Elimination of the age and other limitations with respect to mental illness would be consistent with other Title 19 requirements such as provision of medical services without differentiating on the basis of diagnosis. The present age limitation also tends to exclude those age groups who can best be rehabilitated and returned to the community as constructive useful citizens."

This line of reasoning is further supported in the recently released report of the Task Force on Medicaid and Related Programs which stated: "In such a flexible approach to care based on patients needs, an arbitrary limitation on duration of care of patients in mental institutions is inappropriate, and the Task Force recommends against imposition of any limitation."

In the fact of all of the foregoing it is difficult indeed to understand how it comes about that the bill you are considering today (H.R. 17550) would add yet another discriminatory provision to this category of medicaid recipients.

Mr. Chairman, the National Association for Mental Health urges rejection of this proposed change and instead urges substitution of an amendment which would extend coverage to qualified patients of all ages. This would result in improved services to the mentally ill, in significant financial relief to the States, and in elimination of this unconscionable discrimination towards those millions of Americans who fall victim to this dread illness and to their families who are financially responsible for their care.

Thank you.

The CHAIRMAN. Thank you very much.

I do not know why it is that providing medical care is just a blind spot in our Federal planners when they speak of mental illness. Why, I do not understand. There is a great potential here to restore people to productive society and, as anxious as they seem to be to spend more and more money and to pay far more than anybody estimated to be the case to care for other illnesses and to do research in the field, they just seem to want to hope that mental illness will go away if you don't do anything about it.

I think it makes no sense at all. I hope to support your position.

Mr. FREELUND. Thank you so much.

The CHAIRMAN. I appreciate the fine statement that you have made. I have read Mr. Bussie's statement, too.

Mr. FREELUND. Thank you.

The CHAIRMAN. Senator Anderson?

That concludes today's hearing. We will stand in recess until 10 o'clock tomorrow.

(Whereupon, at 3:30 p.m., the committee adjourned, to reconvene at 10 a.m., on Tuesday, September 15, 1970.)

SOCIAL SECURITY AMENDMENTS OF 1970

TUESDAY, SEPTEMBER 15, 1970

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

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Talmadge, Williams of Delaware, and Bennett.

The CHAIRMAN. Good morning.

The hearing will come to order.

The first witness scheduled is Senator John Sparkman, the senior Senator from Alabama.

Is Senator Sparkman here?

If not, then, we will call the next witness, Mr. Andrew Biemiller, director, Legislative Department, AFL–CIO.

Mr. Biemiller, we are happy to see you here.

There will be more of our members along as the hearing progresses.

Mr. Biemiller, I am glad to see you have recovered from your illness.

Mr. BIEMILLER. Thank you, Mr. Chairman. I am back on my feet, and I think I am in pretty good shape.

Mr. Chairman, I am accompanied by Bert Siedman, Director of the Social Security Department.

The CHAIRMAN. If you do not mind, Mr. Biemiller, Senator Sparkman has just arrived and I will ask you, if you would, to yield your seat.

STATEMENT OF HON. JOHN J. SPARKMAN, U.S. SENATOR FROM THE STATE OF ALABAMA

Senator SPARKMAN. Good morning, Mr. Chairman.

Thank you very much.

I am sorry to be late, but I had constituents in my office, and you know what that means.

Mr. Chairman, I appreciate very much the opportunity to testify on my amendment, which is No. 807, to H.R. 17550.

That amendment addressed itself to what I believe is an unfortunate provision of section 225 of the bill.

As you know, section 225 is intended to provide incentives under the medicaid programs to the several States to provide outpatient care, intermediate care, and home care in preference to skilled nursing home care. Certainly, I am in sympathy with the basic purpose of the sec-

tion, because I agree that wherever possible patients should be removed from skilled nursing homes into one of these other three less intensive types of care, that is to say, outpatient care, intermediate care, or care by family members in the home. This will not only mean a savings in funds, but many times the patient himself will be happier under some kind of program of care other than the intensive care provided in a skilled nursing home.

However, under the provisions of section 225, no exception is made for those patients who need skilled nursing home care for extended periods of time. As you know, under the bill, the Federal medical assistance percentages will be decreased by 33⅓ percent in any year after a patient has received care as an inpatient in a skilled nursing home for as much as 90 days.

Mr. Chairman, it seems to me that this provision is entirely unrealistic. Although there may be patients in skilled nursing homes who could be treated elsewhere, on the average, patients who enter skilled nursing homes are not candidates for substantial rehabilitation. The statistics will bear this out. Seven out of 10 patients who enter a skilled nursing home in the United States are 74 years of age or older. Nearly half of them need assistance in walking. Twenty-five percent of them cannot walk at all. Half of them are confused mentally most of the time. The average length of stay in a skilled nursing home in the United States is in excess of 2 years. It is sad, but true, that in most instances the skilled nursing home is the last home the patient knows.

Under my amendment, Mr. Chairman and members of the committee, the basic purpose of section 225 will be retained. That is, if the section is changed in accordance with my amendment, wherever it can be shown by the medical review provisions of the law that a patient in a skilled nursing home can be adequately cared for under a less intensive program of care, the funds applicable to that patient would be reduced as provided in the bill. However, my amendment would provide that where, pursuant to the medical review, it is determined that the patient needs continued skilled nursing home care for a period longer than 90 days, that patient could continue to receive the care that he needs without any reduction of funds.

Mr. Chairman, if my amendment is not adopted, a few States may be able to provide the funds necessary to finance a program of long-term care that is needed by its citizens. Not many States will be able to do that, however, and the result will be that skilled nursing homes will not be able to continue operating and skilled care will not be available to those of our citizens who need it.

I have strongly supported the provision of intermediate care facilities throughout the country. It is a service that is needed, and those facilities that have been built and operated have done and are doing a good job of providing this kind of care for our people. On the other hand, I know that so many of our citizens, especially our senior citizens, need a more intensive type of care, and they need it on a long-term basis.

I hope that the committee will amend section 225 in accordance with my amendment.

Thank you very much.

The CHAIRMAN. Thank you.

Senator Sparkman, what do you think of changing the House provision, section 225, to exempt from the cutback States which can show they have effective medical audit and utilization review programs?

Senator SPARKMAN. I do not know, because I do not know what is implied in that. I do not know what it would call for.

I provide in my amendment that this would be extended only to those who show up on the medical review that they need continued skilled nursing care. In other words, it is not a cover-all by any means.

I have supported the—I have recognized all along that we need more intermediate-care homes.

Just 2 years ago, I believe it was, I introduced an amendment to a housing bill that we were considering to allow FHA to insure intermediate home facilities just as in the past we have been able to insure loans to regular nursing homes.

Now, that program has not been in effect long enough to let this develop.

I introduced the original bill amendment that permitted FHA to insure nursing homes. Of course, there is a program under Hill-Burton whereby some of them are built. But, I believe, the record will show—I do not know; I have not seen any figures, but I think the record will show—that more of them in recent years have been under FHA insurance than the other way.

They have not had time for this intermediate program to get developed to the extent that nursing homes do have the facilities there in which to transfer them over to intermediate care; so, in some instances, nursing homes are terribly burdened because if they keep the person on they have to keep them in a skilled nursing home facility.

What my amendment would do would be to say that where the medical review shows that this person should continue to receive skilled nursing care, then, the penalty ought not to apply.

The CHAIRMAN. Thank you very much.

Senators, are there any questions?

Senator TALMADGE. Senator Sparkman, I want to congratulate you on your amendment and your testimony. I concur with your remarks.

I think what we need to do is tighten up on the utilization review to prevent people from going into intensive care nursing homes who should not be there, rather than cutting them off after they are admitted.

I have been in many of these nursing homes, and the type patients that you described are what I have seen from time to time, people who are frequently completely helpless, and it would be grossly unfair to throw them out and make them objects of charity.

Senator SPARKMAN. Well, thank you.

Thank you very much, Mr. Chairman, and gentlemen.

The CHAIRMAN. Thank you very much, Senator Sparkman.

Next we will hear from Mr. Andrew J. Biemiller.

We thank you, Mr. Biemmiller, for your courtesy and kindness to our colleague, Senator Sparkman, who, I believe, is one of your most cooperative associates in trying to do things that you believe to be for the good of the rank-and-file people of this country.

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, LEGISLATIVE DEPARTMENT, AFL-CIO; ACCOMPANIED BY BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO

Mr. BIEMILLER. Correct, and an old friend from my House days.

The CHAIRMAN. Right.

We will incorporate in the record the statement that I have here, because I do not think you hope to read all of it.

Mr. BIEMILLER. I would appreciate it, if you would incorporate the entire statement and the appendages.

Mr. Chairman, I am accompanied by Mr. Bert Seidman, who is director of the department of social security, AFL-CIO.

Mr. Chairman, the AFL-CIO was disappointed with the social security bill passed by the House of Representatives. The provisions relating to the OASDHI program fall far short of making a major impact on the economic problems faced by social security beneficiaries. We vigorously oppose those provisions of the bill that would cut back the coverage and services under the medicaid program.

Let me turn first to needed improvements in the OASDHI program. I am sure all members of the committee will agree that benefit levels are not adequate. The issue is: How much of a benefit increase is needed? Certainly, the 5-percent across-the-board increase in the House bill is totally inadequate.

A recent study by the Social Security Administration showed that 44 percent of the social security beneficiaries were poor, another 11 percent near poor. The poverty standard devised by the Social Security Administration and used in the study was $2,020 for a couple and $1,600 for a single person. The respective figures for near poor were $2,690 and $1,900. We know of no other reputable agency or expert who has defined what income makes one poor or near poor with lower figures. The average social security benefit payments today are for a couple, $198 a month, and for an individual, $117 a month. Both are well below these poverty standards. Of course, many receive benefits far below these amounts.

In our testimony before the House Ways and Means Committee in 1969 in support of S. 1300 and H.R. 14430, we urged a 20-percent increase for 1970 followed by an additional 20 percent in 2 years. In urging these two steps of 20 percent, we envisioned a major improvement in the real income and standard of living of our senior citizens. Current inflation has made this goal impossible since the 15-percent increase is supplemented only by the 5 percent in the House bill. We urge passage of an immediate 10-percent increase and an additional 20 percent effective January 1, 1972.

In addition to the 5-percent benefit increase, the House bill would automatically adjust benefits annually if there were a 3-percent increase in the cost of living over the previous year. We feel major improvements must be made in the benefit structure. A cost-of-living escalator should not be adopted unless it is clear public policy that there will be periodic increases in benefits in addition to those related to rising living costs.

A cost-of-living escalator will not solve the poverty problems of the elderly; only a major increase in cash benefits will. The only solution to poverty among the aged is adequate benefits.

We support the provision of the House bill that would increase the amount of the social security benefit payment to widows. This proposal would probably do more to alleviate poverty among the aged, per dollar of cost, than any other change that could be made in the law.

The House bill computes benefits for men on working years up to 62 instead of 65, the same as it is for women. This is a worthy proposal and should be enacted into law.

The House bill raises the present exempt amount of earnings from $1,680 to $2,000. Benefits would be reduced $1 for each $2 of earnings in excess of the exempt amount of $2,000. The exempt amount would be adjusted automatically in accordance with increases in covered earnings.

The proposed change is largely an adjustment for the increase in wages since the present earnings exemption was adopted, and we do not oppose it. However, we believe it would be preferable to put some limit on the $1 and $2 exemption above $3,000.

We were disappointed in that H.R. 17550 did not include a substantial increase in the minimum benefit. We urge a first-step benefit increase to $90 a month and a second-step increase in 2 years to $120. Most beneficiaries receiving minimum benefits are poor, some far below the poverty level. If we are to end poverty among the elderly, we must make major strides toward the provision of an adequate income based on social security benefits.

The House bill leaves untouched the problems that arise from the growing problem of involuntary early retirement and disability. Presently, more than half the men and women who apply for social security benefits are retiring before age 65 and suffering an actuarial reduction in benefits. We urge a number of improvements to deal with the interrelated problems of old age, disability and unemployment which are reflected in what is largely forced retirement. A less than full actuarial reduction, an occupational definition of disability for workers after age 50 to 55, and additional dropout years in the computation of the average wage to better reflect current earnings, would provide additional protection against unemployment, illness, and low earnings.

A major shortcoming in the medicare law is the lack of reimbursement for prescription drugs. Per capita drug expendiutres for the aged are more than 3 times the per capita outlays for drugs purchased by those under 65. Studies show that about 80 percent of the costs of these prescription drugs have to be paid for out of pocket for the elderly. The problem has been studied numerous times by expert bodies all of which invariably recommend coverage. Mr. Chairman, there is no further need for study; only a need for action.

We are particularly distressed that the House did not include the disabled under medicare. Disabled social security beneficiaries use 7 times as much hospital care as does the general population and 3 times as much of physicians' services. The problem of severely restricted income that the disabled beneficiary faces is the very same as that of the retired elderly person. There is a clear and urgent need for coverage of the disabled under medicare.

The premium for medicare's supplemental medical insurance program, originally $3 per month, was increased from $4 to $5.30 ($10.60 for a couple) on July 1—nearly an 80 percent increase in 4 years.

For the great majority of medicare beneficiaries this increase represents a crushing financial burden. We urge that part A and part B be combined into a single program, that the premium for part B be eliminated and that the Government make a general revenue contribution to the trust fund equivalent of one-half the cost of the program.

The House bill calls for an increase in the wage base to $9,000 and an automatic adjustment of the contribution and wage base. These are steps in the right direction. We urge a wage base increase to at least $15,000. The increase in the wage base is not only important as a means of financing a broader program but reducing the regressivity of the tax. It also results in keeping benefits more nearly in line with rising earnings. It reflects the fact that the social security system is important to workers with average and above-average earnings as well as to those with low incomes.

The House bill also would increase the contribution rate in future years to ultimately reach 6.5 percent by 1987 as contrasted to the 5.9 percent rate now scheduled for that date. AFL-CIO members have always been willing to pay their fair share of necessary and desirable improvements in the social security law and feel that the program should be financed primarily by contributions of employers and employees. But the contribution rate required for essential major reforms would place an unfair burden on the low- and middle-income wage workers, since considered solely as a tax, the social security contribution is regressive. Therefore, the time has come, Mr. Chairman, to begin a systematic introduction of general revenue financing in order to establish a fully adequate social security system.

We strongly support the option which is in the House bill for medicare beneficiaries to receive health services through a health maintenance organization. This proposal will stimulate the Nation's physicians, hospitals and other health institutions to utilize this more efficient means for providing adequate services and at the same time control costs.

Health maintenance organizations would serve medicare beneficiaries only if they provide health services at less cost but equal in quality and scope to those offered by the medicare program in the community. It is important to include inducements for providers of services to organize and for beneficiaries to enroll in HMO's. We urge a guaranteed percentage of 95 percent as an inducement to organizations to expand and start such programs and to provide additional services to encourage beneficiaries to enroll. In addition, special and more generous funding provisions are needed for poverty areas and newly starting HMO's.

There are several proposed changes in the medicaid law that cause great concern which, if enacted, could fatally undermine the promise and potential of this program.

One proposed change would repeal the requirement in the present law that States must have comprehensive medicaid programs by 1977.

We urge this committee to reject this House provision. It constitutes a severe retrogression and might postpone for decades the attainment of the goal of comprehensive health services for the needy and medically needy.

The House bill also would modify the requirement for uniform Federal matching for all health services under the State plan resulting

in a reduction of Federal matching money for long term institutional care with inevitable cutbacks in State medicaid programs. If there is concern that too many remain too long in institutional settings with resulting higher costs to the program, the appropriate solution is to assure genuine alternative arrangements suited to the needs of patients. We should not place the burden on those who can least afford it.

We support a large majority of the proposed improvements to increase the operating effectiveness of the medicare program, but we feel they do not go far enough. Efforts to lay the foundation for payment of providers on a prospective basis, authority to terminate or suspend payment to providers who abuse the program, and reimbursement to providers based on comparison of the cost of covered services by various classes of providers in the same geographical area, all are excellent proposals. We oppose the broadened coverage of physical therapy services without greater quality controls and the restriction on hearing rights of medicare beneficiaries. Additional suggestions for improving efficiency are discussed in more detail in the supplementary statement.

Mr. Chairman, this committee has not forsaken the needs of deserving Americans in the past, and I am sure that you will do your utmost to fulfill the hopes of those who, because of old age, death, disability or illness, look to improved social security to overcome want and deprivation.

(The prepared statement of Andrew J. Biemiller and summary of AFL-CIO recommendations follow. Hearing continues on p. 456.)

AFL-CIO Recommendations as Submitted in Statement by Andrew J. Biemiller, Director, Legislative Department, American Federation of Labor and Congress of Industrial Organizations

SUMMARY

I. Benefit improvements

A. An immediate 10 percent across-the-board increase and an additional 20 percent increase effective January 1, 1972.

B. Support House provision that would allow widows and dependent widowers 65 and older to receive 100 percent of their deceased spouse's retirement benefits, instead of the present 82½ percent maximum at age 62. Those who retire prior to age 65 but after age 62 to receive proportionate increases.

C. Support the House proposal to change the method of computing benefits for men basing the computation on working years up to age 62 instead of 65, the same as it is for women.

D. A first-step minimum benefit increased to $90 a month, a second-step increase in two years to $120.

II. Retirement test

A. Do not oppose House provision raising the exempt amount of earnings from $1680 to $2000 but do believe it preferable to put some limit on the $1 for $2 exemption. Suggest that for earnings between $2000 and $3000, $1 be withheld for each $2 of earnings but recommend that for earnings above $3000, $2 be withheld for each $3 of earnings.

III. Disability and retirement

A. Reduce the amount of the actuarial reduction for early retirement, establish an occupational definition of disability, and allow additional drop-out years in the computation of the average wages. Urge a more flexible law that will allow the individual a greater choice based on health, finances, the nature of his job and the employment situation.

IV. Use of disability trust fund for rehabilitation

A. Increase the trust fund monies that can be used to rehabilitate disabled beneficiaries from 1 percent to 2 percent of the previous year's disability benefits.

V. Medicare

A. Immediate enactment of a prescription drug program.

B. Include social security disability beneficiaries in the Medicare program.

C. Combine Part A and Part B into a single program, eliminate the premium for Part B, and make a general revenue contribution to the trust fund equivalent to one-half the cost of the program.

D. Eliminate the requirement for payment or replacement of the first three pints of blood.

VI. Financing

A. Support the proposed increase in the contribution and benefit base to $9000 as a step in the right direction but urge a second step to at least $15,000 and automatic adjustment thereafter.

B. Gradually increase the now limited general revenue contribution until it covers one-third of the total cost of the program in order to make essential major reforms without placing an unfair burden on low and moderate wage workers.

VII. Health maintenance organization

A. Strongly support the option in the House bill to allow Medicare beneficiaries the option to receive health services through a Health Maintenance Organization. This provision would enable the nation's physicians, hospitals, and other health institutions to utilize this more efficient means for providing more adequate services and at the same time control costs. Thus, it is important to include inducements for providers of services to organize and for beneficiaries to enroll in HMOs and suggest the following modifications to accomplish this:

1. A guaranteed percentage of 95 percent as an inducement to organizations to expand and start such programs and for providing additional services to encourage beneficiaries to enroll.

2. More generous funding provisions for poverty areas and newly starting HMOs.

3. Some provision be made for payment on a non-fee-for-sevice basis for those individuals eligible for Part B of Medicare but not Part A.

4. Health care costs vary in different geographical areas so significantly that it is essential that the concept of geographic comparability be expressed in the statute.

5. Substitution of the word "evidence" in place of the term "proof" in order to insure that newly established but responsible HMOs will be able to enroll Medicare beneficiaries as they begin operation. (Sec. 239 (b) (4)).

6. The HMO option should be available only to nonprofit organizations.

VIII. Medicaid

A. Urge rejection of the amendment in House bill that would remove the requirement in present law that States must have comprehensive Medicaid programs by 1977.

B. Urge rejection of the amendment in House bill that would modify the requirement for uniform federal matching percentage for all health services covered under the State plan—resulting in a reduction in Federal matching funds for long-term institutional care.

C. Oppose allowing States to impose a flat deductible for persons eligible for Medicaid but not eligible for cash public assistance.

IX. Medicare

A. Individuals not eligible for Part A (hospital care) of Medicare should be allowed to enroll on a voluntary basis for this program under the same conditions by which individuals can enroll under Part B (physician services). Similarly, State and local governments should have the option of purchasing Part A coverage for their employees on a group basis.

B. Oppose House provision extending Medicare coverage to include services furnished by a licensed physical therapist in his office until there is greater certainty that quality standards will be maintained.

C. Do not oppose House provision for objective study of Medicare coverage of chiropractic services but deem it essential that any such study include within its scope evaluation of the scientific validity of chiropractic theory.

D. Oppose House proposal requiring a minimum amount of $100 be at issue before a beneficiary will be granted a hearing by the intermediary.

E. Do not oppose House provision that would disallow capital costs such as depreciation and interest made for capital expenditures in excess of $100,000

which were specifically disapproved by State and local health planning bodies as long as provision requiring final approval by the Secretary of HEW on recommendation of a National Advisory Council is retained.

F. Support House proposal that reasonable physician fees will be defined as those which do not exceed the 75th percentile of actual charges in a given area during calendar year 1969. In order to insure that the savings realized by this provision will not be at the expense of poverty-stricken older people, we urge a requirement that doctors use the assignment method.

G. Strongly support the requirement in House bill that HEW be required to develop experiments and demonstration projects designed to test various methods of making payment to providers on a prospective basis.

H. Urge adoption of House provision that would give the Secretary of HEW authority to establish limits on providers' costs to be recognized as reasonable based on comparisons of the cost of covered services by various classes of providers in the same geographical area.

I. Urge that HEW be given authority as provided in House bill to terminate or suspend payment for future services rendered by a provider found to be guilty of abusing the program.

J. Amendment 851 (Bennett proposal) contains many unknown and unpredictable factors. Therefore, the proposal should be tested along the lines Senator Bennett has suggested before Congress considers putting it into effect on a total basis. In the meantime, House provisions strengthening peer review should be enacted.

X. Additional AFL–CIO recommendations

A. Relationships between parties that pay for health care on behalf of the public on the one hand and the providers of care on the other, should whenever possible, be contractual. Where there is no contract, fee schedules should be used instead of the usual and customary fee.

B. Hospitals should be required as a condition for participation in the programs to employ a full-time medical director and various department heads and all hospital-based physicians should be paid by the hospital in order to give hospital administrators greater control of the hospital's budget.

C. All hospitals as a condition of participation in the programs should be required to establish a formulary of prescription drugs and to purchase drugs for this formulary by generic name on a competitive basis.

D. The federal government should expand present health professions education programs to provide more scholarships, additional funds for student loans, and to encourage more effective use of auxiliary personnel as a means of increasing the productivity of physicians.

STATEMENT

Thirty-five years ago, Congress passed the Social Security law and made the concept of social insurance a national policy. Congress has improved this law over the years until it has become a main bulwark of national social policy.

Today, 92 percent of those reaching age 65 receive social security benefits. The Medicare program covers nearly 20 million people. Nineteen of every 20 widows and young children are protected in the event of death of the family breadwinner and more than 67 million people under age 65 are insured in the event of severe disability.

It is important to stress these latter protections and emphasize more strongly that social security is not only a retirement system but a program that protects the family when the breadwinner dies or is disabled. These vital protections are often overlooked by younger workers who need them most. But despite the progress and the broad scope of the program, it falls far short of meeting the minimal needs of most of those protected by it.

The largest group dependent on social security benefits are elderly retirees whose economic situation is all too often woefully sad. I would like to document how bad that situation is. Recent Social Security Administration research on the income of people aged 65 and older, based on data for 1967, shows how low is the income level for the large majority of the elderly. This research showed that 44 percent of the social security beneficiaries were poor, another 11 percent near poor. Only one-third of the couples had incomes sufficient to permit a moderate level of living defined by the Bureau of Labor Statistics budget for a retired couple ($3930).

As poverty has become a problem of national concern there have been a number of attempts to more precisely define it. The poverty standard devised by

the Social Security Administration and used in the study was $2020 for a couple and $1600 for a single person. The respective threshold figures for near poor were $2690 and $1900. I know of no other reputable agency or expert who has defined with lower figures what income makes one poor or near poor. The average social security benefits today both for a couple, $193 a month, or for an individual, $117 a month, are well below one or both of these poverty standards.

The social security benefit is clearly vital to the economic survival of the aged. It has played a major role in holding down the degree of poverty among them and mitigating its impact on those who remain poor. If it were not for social security benefits, nearly 3 times as many beneficiary couples would have been in poverty in 1967 and only 20 percent instead of one-third would have had sufficient income to reach the income level of the BLS moderate budget.

Of the regular beneficiaries without spouses, largely widows, 80 percent would be the victims of poverty and an additional 10 percent would be near poor or nearly as bad off—compared with the more than 50 percent that are now poverty stricken and the additional 16 percent that are near poor and hover just above the poverty line.

It is a sad fact that the aged are the single largest poverty group in our nation. The percentage that the aged constitute of the poor is increasing for they are not leaving the poverty population as rapidly as those in the younger age groups. The solution to poverty among the aged is not education manpower training or related programs since most are unable to work or even to obtain jobs if they can. The basic solution lies simply in the guarantee of a modest yearly income.

It is true that the 1968 and 1970 increases in social security benefits have enabled beneficiaries to inch ahead in their continual, often futile, race with the cost of living. It is evident, however, that rapidly rising living costs will soon wipe out this slim lead. The consumer price index has accelerated from a rise of 5.0 percent in 1969 to an annual rate of increase of 5.9 percent in the first 7 months of 1970. If the benefit increase passed last year is supplemented by only a 5 percent increase this year, beneficiaries are likely to suffer a decline in the real value of their already inadequate benefits during the interim before another benefit increase takes place.

Not even the AFL–CIO, which has been critical of Administration economic policies and accurately predicted the limited results of that policy, foresaw the extent and duration of current inflation. In our testimony before the House Ways and Means Committee in 1969, we urged a 20 percent increase for 1970 followed by an additional 20 percent in two years as provided in the Williams-Gilbert Bill, S. 1300 and H.R. 14430. In urging these two steps of 20 percent, we envisioned a major improvement in the real income and standard of living of our senior citizens. Current inflation has made this goal impossible if the 15 percent increase of last year is supplemented only by the 5 percent in the House bill. We urge passage of an immediate 10 percent increase and an additional 20 percent effective January 1, 1972.

In addition to the 5 percent increase, the House bill would automatically adjust benefits annually if there were a 3 percent increase in the cost of living over the previous year. We feel major improvements should be made in the benefit structure so that benefits will be at a more adequate level before any cost of living escalator becomes operative. Nor should a cost of living escalator be adopted unless it is clear public policy that there will be periodic increases in benefits in addition to those related to rising living costs. The aged population must be guaranteed the right to participate in the nation's increasing standard of living. Without these assurances, tying benefits to the cost of living could simply render the generally low living standards of the elderly static while those of the rest of the population advance and, thereby, condemn a majority of the elderly to a perpetual substandard way of life.

INCREASE IN WIDOW'S BENEFIT

We support the provision of the House Bill that would increase the amount of the social security benefit payable to widows. At present, they receive 82½ percent of the primary benefit of the deceased spouse at age 62. H.R. 17550 would raise this percentage to 100 percent at age 65. If the benefit begins earlier than 65, it would be proportionately reduced to 82½ percent at age 62.

The 7.4 million women beneficiaries without husbands are the least able to secure work and the most disadvantaged. A recent study showed their median

income was less than three-fourths the median for a man. One-third of them reported less than $1,000 in total money income for the year and only 11 percent reported $3,000 or more. In short, this proposal would probably do more to alleviate poverty among the aged, per dollar of cost, than any other change that could be made in the law.

UNIFORM METHOD OF COMPUTING BENEFITS FOR MEN AND WOMEN

The House bill changes the method of computing benefits for men basing the computation on working years up to 62 instead of 65, the same as it is for women. At present, the formula can result in significantly lower earnings being paid to retired men than to retired women with the same earnings. This change would be of particular help to those men who are forced to retire before age 65 on actuarially reduced benefits. Many of them are men who have lost their jobs at an age that makes it difficult to find work or have disabilities that are not severe enough to qualify them for disability benefits. This is a worthy proposal and should be enacted into law.

RETIREMENT TEST

The House bill would raise the present exempt amount of earnings from $1680 to $2000. There would be a reduction in benefits of $1 for each $2 of all earnings in excess of the exempt amount of $2000. The exempt amount would be adjusted automatically in accordance with increases in earnings. The AFL-CIO has long opposed elimination or undue liberalization of the retirement test. Its elimination would benefit primarily those 800,000 persons working full time and would likely come at the expense of more adequate cash and medical benefits for the large majority of beneficiaries who are unable to work because of poor health or lack of employment opportunities.

The proposed change is largely an adjustment for the increase in wages since the present earnings exemption was adopted and we do not oppose it. However, we do believe it would be preferable to put some limit on the $1 for $2 exemption, above $3000. We suggest that for earnings between $2000 and $3000, $1 be withheld for each $2 of earnings but recommend that for earnings above $3000, $2 be withheld for each $3 of earnings.

Because of taxes and work expenses, a beneficiary's spendable income may actually be less if he earns more than the amount of income specified as the point where the dollar for dollar reduction takes place. This proposal takes care of that problem by eliminating the full dollar for dollar reduction. We believe this approach preferable and that any savings resulting from adoption of this latter proposal be used to make improvements in the law.

Other social security proposals recommended by administration

The administration proposes several additional changes in the old age, survivors, and disability insurance law which deserve support. One would eliminate the actuarial reduction that takes place in the alternative wife's benefit when a woman applies for these benefits at a later date after first receiving actuarially reduced benefits on her own account prior to age 65. A second would make disability benefit payable to an adult son or daughter (if the insured parent dies, becomes disabled or retires) who becomes totally disabled before he reaches 22, rather than 18, as under present law. A third would make the eligibility requirements for both the retirement and disability programs the same for blind persons. A fourth would allow combined payments from workmen's compensation and the social security disability program to equal 100 percent of average wage without reduction. Others would provide wage credits for members of the Armed Forces for the period from 1957 to 1967 and would eliminate proof of support requirements for divorced wives, divorced widows, and surviving divorced mothers in order to receive benefits when marriage lasted 20 years.

Though most of these changes are minor in terms of cost and impact they do provide a greater measure of justice for the various groups involved and, in many cases, are of vital importance to those affected by them. All of them should become law.

The AFL-CIO profoundly regrets that the House bill does not contain many major social security reforms recommended by the AFL-CIO and I would like to comment on some of them.

MINIMUM BENEFIT

We were very disappointed that H.R. 17550 did not include a substantial increase in the minimum benefit. Social security beneficiaries who must rely on the minimum benefit of $64 per month to pay for the skyrocketing prices of food, clothing, and shelter are the most tragic victims of inflation. Yet to offset skyrocketing inflation, the House bill would increase the minimum benefit by a mere $3 a month.

According to recent surveys, of those beneficiaries receiving the minimum benefit, 50 percent of the couples, 70 percent of the unmarried men, 76 percent of the unmarried retired women workers, and 84 percent of the widow beneficiaries were living in poverty. Thus, any increase in the minimum benefit would go overwhelmingly to poor or near poor beneficiaries.

We urge a first-step minimum benefit increase to $90, a second-step increase in 2 years to $120. If we are to end poverty among the elderly, we must make major strides toward the provision of an adequate income based on social security benefits. Our proposal would constitute a significant step toward insuring that the poorest of our aged citizens would be able to live in dignity, free from the ever-present spector of impending financial disaster.

DISABILITY AND RETIREMENT

The House bill leaves untouched the problems that arise out of the growing problem of enforced early retirement. At the present time, more than half of the men applying for social security benefits are retiring before age 65, accepting the consequent actuarial reduction in benefits. No one believes that with the average primary benefit currently awarded—about $117 a month—very many of these men are retiring of their own free will. What is undoubtedly reflected here is an indirect effect of automation and other factors causing the displacement of workers. If the economic system is forcing men and women to retire early, then the social security program will have to be adjusted to meet the facts of modern life. At the very least, the amount of the actuarial reduction should be reduced.

A number of improvements to deal with the interrelated problems of old age, disability and unemployment come readily to mind. We urge an occupational definition of disability so that older workers after age 50 and 55 could receive disaiblity benefits if their disability prevented them from doing their usual occupation. Another change that is clearly called for is to allow additional dropout years in the computation of the average wage. This would result in an average wage more nearly reflecting current earnings which would provide additional protection against unemployment, illness, and low earnings. In short, we urge a more flexible law that will allow the individual a greater retirement choice based on his health, finances, the nature of his job, and the employment situation.

USE OF DISABILITY TRUST FUND FOR REHABILITATION

Present law authorizes payment from the disability trust fund for rehabilitation services to totally disabled beneficiaries. Maximum total reimbursement cannot exceed 1 percent of disability benefits paid in the previous year. More than 15 000 beneficiaries have been reported as rehabilitated by the State agencies and more than 4,000 have been terminated from the benefit rolls since this program began. The overall value of savings to the trust funds is more than 60 percent higher than the value of trust fund rehabilitation expenditures.

The State rehabilitation agencies requests have exceeded available funds under these provisions for the last 3 fiscal years. We urge that the trust fund moneys used for this purpose be increased from 1 percent to 2 percent of the previous years' disability benefits. This would allow many additional disabled beneficiaries to receive rehabilitation and also would result in reduced benefit payments greater than the cost of the services. Though the well-being of the beneficiary is the primary consideration, the results benefit everyone.

MEDICARE

Prescription drugs

One of the greatest shortcomings of the Medicare law is the lack of reimbursement for prescription drugs—drugs which may very well be the greatest single contributor to the advances made in preserving and protecting man's good health.

The elderly account for 25 percent of all outpatient prescription drug costs. Per capita drug expenditures for the aged are more than three times the per capita outlays for drugs purchased by those under 65. The aged with severe disabilities, of which there are many, can expect per capita expenditures three times greater than those over 65 who are not severely disabled. In other words, very high annual drug bills are common among the elderly.

The Task Force on Prescription Drugs found that only about 2 percent of the prescription drug costs of the elderly were covered by private insurance. About 9 percent of the costs were accounted for by free drugs, either from a physician or through a welfare program. Another 8 percent of the costs were reduced through tax savings. About 80 percent of the remaining cost had to be paid for out-of-pocket by the elderly—many millions of whom live in adject poverty or perilously close to the poverty line.

Congress has been aware of this problem. As you will recall, the Senate passed a prescription drug program under Medicare in 1966. In 1967, as part of the Social Security Amendments, Congress directed the Secretary of Health, Education and Welfare to study in depth the feasibility of the Medicare program covering prescription drugs. A Task Force was appointed, studied the problem for over a year, and then recommended the program cover prescription drugs. In 1969, the Secretary of Health, Education and Welfare in the new Administration appointed another expert Committee to review the findings of the Task Force. This Review Committee also recommended coverage, in fact, urged broader coverage than the original Task Force.

Mr. Chairman, there is no further need for study, only a need for action. We urge immediate enactment of a prescription drug program.

Medicare coverage of the disabled

The advent of the Medicare program has brought about a new era in health care for the elderly which stands in sharp contrast to the plight of another group—the severely or totally disabled. In numbers, those receiving social security disability benefits are not large—about 1.5 million. But in terms of economic vulnerability, their position is precarious.

Disabled social security beneficiaries use seven times as much hospital care as does the general population and three times as much in physician's services. In fact, disabled persons have two to three times the need for medical and hospital care as retired persons. Yet, the problem of severely restricted income that the disabled beneficiary faces is the very same as that of the retired elderly person. The disabled cannot afford expensive, individual health insurance policies even when available to them.

The Advisory Council on Health Insurance for the Disabled appointed pursuant to the 1967 amendments completed a comprehensive study of the problem in 1969 and recommended coverage. Unfortunately, the House has not accepted this recommendation but has instead referred the matter to the present Advisory Council on Social Security for study. We see no need for further study. There is a clear and urgent need for coverage of the disabled under Medicare. We urge that the bill this Committee recommends provide for this protection.

Combine Hospital (Part A) and Voluntary Medical (Part B) Insurance

The premium for Medicare's supplementary medical insurance program, originally $3 per month, was increased from $4 to $5.30 ($10.60 for a couple) on July 1, nearly an 80 percent increase in less than four years. For the great majority of medicare beneficiaries this increase represents a crushing financial burden. As pointed out earlier in this statement, most of our older citizens are now receiving shockingly inadequate incomes and almost all of them are already bearing extremely heavy medical expenses not yet covered by Medicare.

Though the Medicare Part B Premium is only one aspect of the increasing burden of medical care costs for the elderly, we can deal with this problem immediately and directly. We urge that Part A (hospital care) and Part B (doctor care) be combined into a single program, that the premium for Part B be eliminated and that the government make a general revenue contribution to the trust fund equivalent to one-half the cost of the program.

BLOOD DEDUCTIBLE

There is one improvement in the Medicare law which is long overdue. Under present law, the patient must replace or pay for the first three pints of blood used. Those eligible for Medicare are past the age that they can give blood and

so are most of their friends. It is not easy for them to find voluntary donors to avoid paying the blood deductible and many are required to buy commercial blood to meet this burden. Union members make up a major blood donor group and based on our long-time experience, the AFL-CIO urges the elimination of this requirement for payment or replacement of the first three pints of blood.

Financing

In order to pay the additional costs of the social security improvements in the House Bill and to meet the existing actuarial deficit in the Part A hospital insurance program, the House Bill would increase the tax base from $7800 to $9000 a year beginning January 1, 1971. The Health Insurance tax rate will increase next year from a scheduled combined employer-employee rate of 1.2 percent to a rate of 2 percent of covered payroll. However, the scheduled rate for the Survivors and Disability programs (OASDHI) for 1971-72 has been reduced so that the total taxes for both programs for these years are the same as in present law. The total contribution rate will actually be lower under the House bill for the years 1973-74 than would be the case under present law. However, there is a particularly sharp jump in 1975 from 5.2 percent to 6.0 percent and the tax will ultimately reach 6.5 percent by 1987 as contrasted to the 5.9 percent rate presently scheduled for that date.

The increase in the contribution and benefit base of $9000 is a step in the right direction but we urge a second step to $15,000 and an automatic adjustment thereafter. The increase in the contribution rate is not only important as a means of financing the broader program and reducing the regressivity of the tax. More importantly, it results in keeping benefits more nearly in line with rising earnings. Our social security system is important to average and above-average earners as well as to those with low earned incomes.

Over the years, the limitation on earnings for taxes and for the computation of benefits has failed to keep pace with increases in earnings. As a result, the protection provided under the system for those in the higher wage levels has significantly deteriorated. About 95 percent of the persons in the social security program had their full earnings covered when the program first began. It would take a wage base in excess of $15,000 to cover the same proportion today. The program should cover the total earnings of the large majority of workers so that their benefits, which are based on covered earnings only, will be better related to what they have actually earned.

AFL-CIO members have always been willing to pay their fair share of necessary and desirable improvements in the social security law. And we are willing to pay our share of the improvements we are advocating here today if the Congress will enact them into law. The Social Security System should continue to be financed primarily by contributions of employers and employees.

But the time has come Mr. Chairman, to begin a systematic introduction of some general revenue financing in order to establish a fully adequate social security system. The contribution rate required for such major reforms would place an unfair burden on the low wage worker, since considered solely as a tax, this contribution is regressive.

There has been support for a government contribution from general revenues from the inception of the program. Organized labor supported the payroll tax at the time the Social Security program began despite its burden upon low-income workers. However, organized labor and many other supporters of this legislation viewed exclusive reliance on the payroll tax as a transitional stage.

Mr. Chairman, if you will examine the record of the past, you will find that in these early years the Social Security Board, Advisory Councils, Congressional spokesmen, organized labor and even various business groups asserted the need for a general revenue contribution at some appropriate stage in the development of the system. Organized labor believed as did many others that exclusive reliance on the payroll tax was necessary during the initial phase of the program in exchange for the benefits of the new protection. But at the same time, we felt that ultimately action would be taken to limit the burden upon low and middle income groups.

In fact, the original Social Security legislation submitted to Congress in 1935 recommended a government contribution to cover past service credits and even mentioned 1965 as the most likely year when such contributions would be required. Provisions for a government contribution were actually included in the Social Security Act from 1944 to 1950 and though removed in the amendments of 1950, its removal was against the recommendation of the Advisory Council on Social Security.

In addition, government contributions are already being used to meet a minor but nevertheless a significant portion of program costs—wage credits for military service, hospital insurance for the non-insured, matching funds for the Part B premium, and for the age 72 special benefits. In short, Mr. Chairman, this is not a new proposal but an old one that now needs to be fully implemented. We urge a gradual increase in the now limited general revenue contribution until it covers one-third of the total cost of the program.

COST EFFECTIVENESS AND TECHNICAL AMENDMENTS

The House Bill contains numerous complex and technical provisions to control health care costs. We note that many of these reforms are similar to recommendations in the Senate Finance Committee Staff Report on Medicare and Medicaid. This report has performed a public service by pointing out instances of abuses or unsatisfactory performance and has undoubtedly influenced the House legislation. It is imperative, however, in pointing out abuses that we do not create a public impression that may impede basic benefit improvements in these programs.

These programs are built on the established order of hospital and medical services and reflect many of the same problems that are plaguing the health care system as a whole. These shortcomings should not be used as an excuse to deny making major benefit improvements in the laws. Beneficiaries should not be the victims of society's refusal to come to grips with an outmoded health delivery system.

Millions of former union members are covered by these programs, particularly by Medicare. In their letters to us, they praise what the programs have done for them. Their complaints generally are not about poor administration but largely center on the inadequacies of the law. The AFL-CIO has on many occasions pointed out the many shortcomings of these programs—not because we were not aware of the contributions they have made but in order to improve them so that the beneficiaries would be assured medical care of high quality.

The Medicare and Medicaid programs do have fundamental defects in lack of adequate cost controls, but most are beyond the control of their administrators and require legislative action. We support most of the provisions of the House bill to contain costs and to remedy some of these problems but feel they do not go far enough. I shall not attempt to analyze in detail all the complicated and often interrelated provisions of these comprehensive provisions of the bill. Rather, I shall attempt to explain why the AFL-CIO supports or opposes certain major provisions and what additional we feel needs to be done to effectively control costs.

H.R. 17550 would allow persons age 65 or over to enroll on a voluntary basis for Part A (Hospital Care) of Medicare under the same conditions by which idnividuals can enroll under the Part B (Physician Services) of Medicare. Those who do enroll must pay the full individual cost of the protection ($27 a month) would be increased as costs go up. States and other organizations would be allowed to purchase such coverage on a group basis for their retired employees over 65.

This provision would be of benefit to individuals age 65 and over but who are not eligible for Medicare. These individuals find it nearly impossible to purchase private insurance protection since most private insurance policies for the age 65 and over group have been converted to policies supplementary to Medicare. Large numbers of State and local government employees not covered by Social Security and ineligible for Medicare coverage face this problem on retirement. Allowing State and local governments the option of purchasing coverage for them on a group basis would help resolve this problem.

HEALTH MAINTENANCE ORGANIZATIONS

We strongly support the option allowing Medicare beneficiaries to receive health services through Health Maintenance Organization. This proposal will do much to encourage long range improvements in the organization and delivery of health services. It should stimulate the Nation's physicians, hospitals and other health institutions to utilize this more efficient means for providing services and for controlling unnecessary cost.

Physicians in medical groups are today giving prepaid medical care to millions of people enrolled in group practice plans. These physicians work as teams and pool their varied professional skills for the best care of the patient in return for regular payments on an agreed basis. These plans achieve substantial

economies through bringing the various specialities together in one place and through efficient joint use of supporting personnel and expensive equipment. They assure quality medical care through professional review of the qualifications and performance of medical staff.

The accomplishments of group practice plans are gradually attracting increasing support among trade unions because they provide high quality care and because of their value as yardsticks against which the efficiency and costs of other methods of providing and paying for medical care can be evaluated.

However, the House provisions should be strengthened in a number of respects to encourage use of this provision and thereby maximize potential cost reductions and improved quality for the Medicare program.

Health Maintenance Organizations may serve Medicare beneficiaries only if they provide health services equal in quality and scope to those of the Medicare program but will be reimbursed for their costs at not more than 95 percent of comparable Medicare costs in the community. The enrollment of Medicare beneficiaries in this program will result in savings to Medicare and the greater the growth of these programs, the greater the opportunities for reducing costs.

Thus, it is important to provide inducements for providers of service to organize and for beneficiaries to enroll in health maintenance organizations, (HMO). The HMO specifications providing a maximum up to 95 percent but not a minimum percentage does not provide incentives for them to provide much more than minimum Medicare services required. We favor some guaranteed percentage as an inducement to organizations to expand and start such programs and for providing additional services to encourage beneficiaries to enroll. We urge modification of the House provision to permit Health Maintenance Organizations to receive the full amount of the 95 percent of comparable costs for Parts A and B of Medicare in the area served.

In return for this guaranteed percentage, the Secretary of Health, Education and Welfare would insure through regulations and the negotiated contract that income in excess of costs would be used to provide enrollment incentives. These would include items not covered by Medicare (i.e., coverage of Medicare deductibles and coinsurance, outpatient drugs, physical and eye examinations, etc.). This would provide not only incentives for Medicare beneficiaries to enroll in the program, but also encourage more comprehensive health care, and at the same time, reduce the costs of the medicare program.

There is also a need to help start and maintain Health Maintenance Organizations during initial years when start up and overhead costs are large and before sufficient members are enrolled to reduce these costs to levels which can be achieved after the initial period of operation. Similarly, great inequities exist, particularly in poverty areas, due to inequitable distribution and availability of manpower and resources. Obviously, potential HMOs such as neighborhood health centers will have special problems when they are located in ghetto areas where low income groups reside. The application of a ceiling based on a percentage of medicare costs in such an area may be too low because the population is underserved or provided an inferior quality of service under the prevailing but often extremely inadequate health care arrangements in that area.

We suggest, therefore, modifying the provisions of the House Bill to allow newly established HMOs to be reimbursed on the basis of a 100 percent formula with a gradual reduction in this percentage for 5 years at which time the 95 percent formula would apply. We also urge that the Secretary of HEW be given the authority to negotiate contracts with Health Maintenance Organizations in under-served poverty areas at more than 95 percent of the cost in such areas, including contracts providing for a reimbursement formula above the 100 percent level where necessary and appropriate. Any additional costs to the Medicare programs, of course, would be met from the savings realized by the 95 percent contracts with other HMOs.

We also suggest the following technical changes in the bill.

Many individuals are eligible for Part B of Medicare but not Part A. Group practice plans now receive per capita payments for such individuals from the Medicare program. It appears that the House Bill would not permit these individuals to participate in an HMO if the group practice plan chooses this option, which seems likely. It is important that some provision be made for payment for these individuals on a non-free-for-service basic in such situations.

We also urge that the bill clearly spell out the concept of geographic comparability in determining the reimbursement formula. Health care costs vary in different geographical areas so significantly that it is essential that the concept of

geographic comparability be expressed in the statute. This is particularly important to many group practice prepayment plans which operate in metropolitan areas where the cost of health care is the highest.

The Bill provides that HMOs demonstrate "to the satisfaction of the Secretary of HEW proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically." The term "proof" if strictly interpreted might preclude the enrollment of Medicare beneficiaries in new plans since "proof" can only be supplied after a plan has been in operation for sometime. We urge substitution of the word "evidence" in place of the term "proof" in order to avoid any such interpretation and to insure that newly established but responsible HMOs will be able to enroll Medicare beneficiaries as they begin operation.

We feel that financial inducements and technical changes are essential. The Medicare program will save money by the development of HMOs. The greater the growth, the greater the saving to the program. Without these kinds of inducements the growth of HMOs is apt to be limited and far below the potential necessary to make a significant impact on program costs.

There is one feature of the HMO proposal that causes us a great concern. We feel that the proposal should apply only on a non-profit basis and that HMOs should not be allowed to develop as profit making institutions. If HMOs are going to be turned over to individuals for purposes of making a profit, the safeguards against abuse are most likely to be woefully inadequate. The recent Staff Report on Medicare and Medicaid of the Senate Committee on Finance has documented abuses that have occurred in these programs in spite of generally good administration and the best intentioned efforts to prevent them. The long tradition of medical ethics and more than 50 years of hospital standards and accreditation have not been successful in preventing exploitation of patients. Conflict of interest laws are difficult enough to apply to public officials whose every action is subject to intense public investigation and scrutiny. How can law or custom be expected to protect against the desire or profit where medical decisions are private and professional and extremely difficult to measure in any event. In short, we feel that the profit motive inevitably works at cross purposes with quality and comprehensive health care and should be prohibited from the HMO program.

Operation effectiveness and technical amendments

We support the large majority of the proposed improvements to increase the operating effectiveness of the Medicare and Medicaid programs. Most are acceptable and generally represent significant and overdue effort to more adequate control of rising costs of the program. However, there are several major proposed changes in the Medicaid law that cause us great concern and, if enacted, could fatally undermine the promise and potential of this program.

MEDICAID

The first would repeal the requirement in present law that States must have comprehensive Medicaid programs by 1977. The intent of this provision in the present legislation is clear and is the heart of the Medicaid law. It would make comprehensive health services available to all those who cannot pay for the cost of these services because their income is too low. In short, a commitment by the nation to provide health care for all indigent and medically needy Americans. A continuing commitment to this goal is imperative if we are going to successful attack the serious but little known failures of our health care system—particularly among the poor where this failure is the greatest.

Let me point out a few of these failures:

The United States ranks 14th among industrial nations in infant mortality. And the United States is not reducing its infant mortality rate at a greater pace than other countries. Half those nations with lower rates than the U.S. in 1967 had higher rates than the U.S. in 1953.

Data for another accepted index of medical care, maternal mortality, shows the percentage of mothers in the U.S. who die in childbirth lagging 11 other industrial nations. The U.S. ranked second ten years ago.

In another key area, life expectancy, the U.S. record is hardly noteworthy. Among the industrial nations, the U.S. ranks 18th for males and 11th for females. In a related area, middle-aged mortality, a man of 40 or 45 has a better chance of living to 50 than his American counterpart in 15 nations.

An important factor in the poor statistical ranking of the U.S. is that low income people are just not receiving the medical care they need. We think it

significant that nations ranking higher are invariably those that have a system to provide and to finance health care for the great majority of their population, rich and poor alike. Pending enactment of a national health insurance system, which the AFL-CIO favors at the earliert possible date, we are not likely to be successful in raising our health standing among the nations of the world unless we expand the Medicaid program.

We urge this committee to reject this House provision. It constitutes a severe retrogression and might postpone for decades the attainment of the goal of comprehensive health services for the needy and medically needy.

The House bill would modify the requirement for uniform federal matching percentage for all health services covered under the State plan. Federal matching for certain outpatient service's would be increased by 25 percent. But federal matching for long-time institutional care would be decreased by one-third: after the first 60 days of care in a general or TB hospital; after the first 90 days of care per fiscal year in a skilled nursing home; and after 90 days of care in a mental hospital (with a maximum of 275 days during an individual's lifetime.)

Though supposedly aimed at inducing use of less expensive forms of medical care, this proposal would actually result in financially overburdened States cutting back their Medicaid programs at the expense of needy patients requiring long-term care. The average age of Medicaid patients in nursing homes is 85. They suffer from one or more chronic and crippling diseases and the vast majority have no home or family. An arbitrary limitation on duration of the care of such patients is a cruel response to their problems. If there is concern that too many patients remain too long in institutional settings with resulting higher costs on the program, the appropriate solution is to assure genuine alternative arrangements suited to the needs of patients, but not to place the burden on those who can least afford it.

The House bill would allow States to impose a flat deductible for persons eligible for Medicaid but not eligible for cash public assistance. The original purpose of Medicaid was to provide for all people who could not pay for the costs of their medical care. Many of those medically indigent cannot afford to pay out of meager incomes for the deductible and coinsurance now required. If deductibles or co-payments are imposed, and we think they are harmful in all cases, they should at least be related to the recipients' income and resources. A flat deductible will work a financial hardship on those least able to bear it.

MEDICARE

We also have reservations on the modification made in the provisions of the Medicare law relating to physical therapists. Under the Part B medical insurance program, beneficiaries would be covered for the services of a physical therapist in independent practice when furnished in his office or in the patient's home. Total charges for such services could not exceed $100 for a calendar year.

Physical therapy services are, of course, already covered under prescribed conditions in a variety of settings. Since such services cannot be furnished in the therapist's office even though the office is far more conveniently located than the facility to which the beneficiary must travel to obtain these services, we can appreciate the need for this modification.

However, we are always concerned about the quality of care in any health program when specialists with less qualifications then those required for fully qualified physicians are included. Such specialties can play a useful role in health care but should not initiate treatment except on the recommendation and under the general supervision of a qualified doctor. Maintenance of quality standards are most likely to be maintained when such services are provided in an organized medical setting. Though under the proposal the Secretary would be empowered to establish quality controls by regulations, we would prefer that they be more specifically spelled out in the law itself. We will oppose this proposal until there is greater certainty that quality standards will be maintained.

The House bill also contains a provision that would require a study of chiropractic services provided by State medicaid programs in those states that authorize such services. This study would be used in making a determination whether chiropractic services should be covered by Medicare. The AFL-CIO has opposed coverage of chiropractic services by Medicare but do not oppose an objective study of the question. We deem it essential that any such study include within its scope evaluation of the scientific validity of chiropractic theory which maintains that treatment of the spine can cure practically any human illness.

Attached to this statement is a recent AFL–CIO Executive Council Statement which includes within it our position on coverage of chiropractic services by Medicare. Also included in a report by the National Association of Letter Carrier's Health Plan on their experience with coverage of these services. Men who carry the mail probably have more back ailments than any other occupational group. I thought this report on the problems experienced with chiropractic coverage would be particularly worthwhile to call to the attention of the members of the Committee.

We oppose requiring a minimum amount of $100 be at issue before a beneficiary will be granted a hearing by the intermediary. Presently, hearings are permitted when there is controversy regardless of the dollar amount at issue. Amounts less than $100 constitute a large sum of money to the typical social security beneficiary and he should have the right to contest decisions on such amounts.

The House bill would also disallow capital costs such as depreciation and interest made for capital expenditures in excess of $100,000 which were specifically disapproved by State and local health planning bodies. We have opposed similar proposals in the past. We felt that the qualifications of members of Advisory Councils to State Planning Bodies vary widely from State to State and, despite the usual requirement for consumer representation, that the influence of physicians and financial interests was disproportionate to consumer influence in many states. Fortunately, the House bill provides for final approval by the Secretary of HEW on recommendation of a National Advisory Council, and for that reason, we do not oppose it.

By and large, the remaining cost control amendments represent a worthy effort to come to grips with the rising cost of federal health programs. There are several major ones that deserve comment.

For fiscal year 1971, reasonable physician fees will be defined as those which do not exceed the 75th percentile of actual charges in a given area during calendar year 1969. After that, allowable charge increases will be based on the average increases in the cost of production of medical services, levels of living, medical supplies, equipment and services, and earnings of other professional personnel. Presently, the prevailing limit on the reasonable charge for a service is generally about the 83rd percentile.

The AFL–CIO from the inception of the Medicare program pointed out that the reimbursement formula for physicians was biased in favor of escalation of costs and against adequate cost controls. Reimbursement of physicians based on "prevailing" charges is an open invitation to doctors in today's seller's market for medical services to increase their charges so that the new higher level of charges will have to be considered "prevailing." The proposal is a step forward in holding down costs, but better results would be obtained by contractual relationships with providers of medical care and negotiated fee schedules.

In addition, since under present law the physician can choose whether to be paid by direct billing or the assignment method, there is a good possibility that a large portion of any cost savings will be borne by financially hard-pressed beneficiaries. If the doctor chooses billing the patient directly, he may charge what he pleases and the patient must make up the difference. The assignment method, receiving the payment from the Social Security Administration, requires that the doctor accept the reasonable and customary charge as determined by SSA.

Under the new proposal, this would have to be within the 75th percentile of customary charges for a service in the physician's area. In order to insure that the savings realized by this provision will not be at the expense of poverty stricken older people, we urge a requirement that doctors use the assignment method.

We strongly support the requirement that HEW be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis. There is already authority to do this under Section 402 of the Social Security Act but, unfortunately, little has been accomplished. What is needed is a speedy and sustained effort in this area in order to lay the groundwork for a major program of prospective reimbursement. The present "reasonable cost" reimbursement formula neither rewards efficiency nor discourages waste and ignores the opportunity to use money as an inducement to superior performance. Specified payment in advance would put a premium on efficiency and would stimulate more economical use of resources and manpower.

Another provision would give the Secretary of HEW authority to establish limits on providers' costs to be recognized as reasonable based on comparisons of the cost of covered services by various classes of providers in the same geographical area. This provision would be applied prospectively so that providers would know in advance maximum costs allowable and would have an opportunity and incentive to achieve economies to avoid non-reimbursable costs. There is authority in existing law to disallow incurred costs that are not reasonable but excessive costs must be specifically proved on a case-by-case basis. Administratively, this is too cumbersome to effectively control costs.

An institution that is inefficient in the delivery of health services should not be shielded from the economic consequences of its inefficiency. A reimbursement formula based on costs—which allows whatever costs a particular institution incurs—is not responsive to efficiency objectives. It is appropriate that a reimbursement formula only recognize those costs incurred by a reasonably prudent and cost-conscious management.

Another provision in the House bill is long overdue. HEW would be given authority to terminate or suspend payment for future services rendered by a provider found to be guilty of abusing the program. Under present law, HEW does not have this authority. Nothing is more important than protecting beneficiaries from inferior or harmful services and from fraud and this cannot be properly done under the limitations of existing law.

The AFL-CIO favors strengthening peer review under the Medicare and Medicaid programs by both administrative and legislative means. The aforementioned provision in the House bill embodies within it review of both individual cases and review of statistical data. We believe this approach preferable to that of Amendment 851 which has been proposed on peer review. This latter proposal provides only for review of questionable cases and there is no statistical review of data and consequently, no basis for making recommendations from statistical review. In addition, the proposal would vest the appointment authority in medical societies and confine membership on review groups to physicians and does not include consumer representation. Finally physician peer review should not cover decisions that are basically administrative such as whether charges are excessive or not. Administrators and health planners are better qualified to make those kinds of judgments and others that pertain to organization and patterns of services.

These and other reforms of the House Bill would help resolve many of the cost problems of the Medicare and Medicaid programs but we feel others are essential and urge the following additional reforms:

1. Relationships between parties that pay for health care on behalf of the public on the one hand and the providers of care on the other, should whenever possible, be contractual. Where there is no contract, fee schedules should be used instead of the usual and customary fee.

2. Hospitals should be required to employ a full-time medical director and various department heads and all hospital-based physicians should be paid by the hospital in order to give hospital administrators greater control of the hospital's budget.

3. All hospitals, as a condition of participation in the programs, should be required to establish a formulary of prescription drugs to purchase drugs for this formulary by generic name on a competitive bid basis.

4. The Federal Government should expand present health professions education programs to provide more scholarships, additional funds for student loans, and to encourage more effective use of auxiliary personnel as a means of increasing productivity of physicians.

In the long run, only the adoption of a national health insurance program will guarantee a health care system capable of providing comprehensive quality care and of containing cost increases. But the need for a comprehensive national health program should not detract from the need of making these essential changes in the existing programs as soon as possible.

STATEMENT BY THE AFL-CIO EXECUTIVE COUNCIL ON SOCIAL SECURITY AND MEDICARE

The 15 percent across-the-board increase in Social Security benefits enacted into law by the Congress in late 1969 was an appropriate response to the spiraling living costs faced by America's senior citizens. We are gratified that the Congress rejected the President's recommendation of a mere 10 percent. Obviously, there

are many other improvements which should be made in the Social Security law. But the dire need for a benefit increase could not wait on the lengthy deliberations that a complex Social Security bill requires. Enactment of the 15 percent increase should not be the end but only the beginning of action by Congress in the whole area of Social Security reform and improvements.

The 15 percent increase did not resolve the depressing financial squeeze bearing down on millions of older Americans. The rise in the consumer price index has been almost 10 percent since the effective date of the last Social Security increase, and by the end of the year will fully equal the 15 percent benefit increase. Social Security beneficiaries will once again fall behind in their unceasing battle with rising living costs with no improvement at all in their living standards. Three out of ten older Americans have been living in poverty and another 20 percent just above the poverty line. This situation has not been materially altered by the benefit increase.

Adding to the economic burdens of the elderly has been the decision of the Secretary of Health, Education and Welfare to raise the premium of Part B of Medicare (doctor bills) by 32 percent—from $4.00 to $5.30 per month. Thus the higher Social Security benefits are, in effect, reduced by the substantially higher Medicare payments the elderly must make in addition to serious erosion by the cost of living.

The substantial rise in Medicare premiums represents a heavy financial burden to the typical Social Security beneficiary. It is all the more onerous when coupled with previously announced increases in Medicare deductibles and co-insurance which also require the elderly to make heavy out-of-pocket payments.

The labor movement fought for the enactment of Medicare to relieve the elderly of burdensome medical costs. They must not be saddled with financial burdens Medicare was intended to relieve. If this trend were to continue, large numbers of the elderly would be compelled to withdraw from the program. Just as before Medicare, they would have no way of meeting their urgent medical needs.

The Administration has made no proposals to relieve this problem and is placing the burden of inflationary medical costs upon those who have the greatest need for medical care but the least capacity to meet these rising costs. To deal with this tragic situation, the AFL-CIO urges that the voluntary Part B (doctor bills) be combined with Part A (hospital bills) into a single program and thus permit the entire financing of medical care during a beneficiary's working life and remove the burden of premium payments after retirement.

But the Medicare program must be more than a mechanism through which money is funneled to pay health care costs. When daily hospital charges have gone up almost five times and doctors' fees twice as fast as the consumer price index, a systematic and sustained effort must be made to hold down costs and to devise new approaches for delivery of health care at controllable costs. The only satisfactory solution is National Health Insurance. Until it is enacted, the government has an obligation in existing programs like Medicare to use the billions of dollars it spends for health care as an economic lever to induce fundamental changes in the traditional, outmoded and costly methods that prevail in the delivery of health services. This will help to control the cost of medical care.

Of equal importance to holding down costs is the maintenance of quality care in the Medicare program. Of immediate concern is the threat to quality care represented by the drive to include less than fully qualified medical practitioners such as chiropractors in the Medicare program. At stake is the direct access to the billions of dollars for health care being provided the elderely by the Medicare program. Medicare should not become a vehicle for exploitation of the health needs of the elderly. The AFL-CIO opposes any change in the Medicare law which would open up the program to unqualified practitioners.

The chairman of the House Ways and Means Committee has already indicated that the committee will continue its review of Social Security and Medicare and will report a comprehensive bill to the House by March. Bold reform and not patchwork is essential if America is to provide its elderly the dignified secure retirement they deserve. We urge reforms along the lines of H.R. 14430, introduced by Congressman Jacob Gilbert and S. 3100, introduced by Senator Harrison Williams. We call for these major improvements in Social Security and Medicare:

An immediate 20 percent across-the-board increase (including the 15 percent recently enacted) as a first step to be followed by an additional 20 percent in two years. Thereafter, benefits should be adjusted in accordance with some

appropriate measure of increases in wage levels so beneficiaries can participate in the increased standard of living they made possible.

A cost of living mechanism would be a good first step only if it is a clear public policy that benefits will be adjusted upward periodically in addition to cost of living adjustments.

Increase the minimum benefit to $90 for a single person and $135 for a couple with a further increase in 1972 to $120 and $180 respectively.

Base a worker's benefit on his highest ten years' earnings out of any 15 consecutive years after 1950.

A 100 percent widow's benefit at age 65.

Less than full actuarial reduction for early retirees (those who retire between ages 62 and 65).

Increase the amount of income a person can earn and still get full social security benefits.

Raise the lump-sum death payment to $500.

Liberalize the definition of disability and reduce the disability waiting period from 6 to 3 months.

Eliminate the age 50 limitation for disabled widows and increase this payment to equal regular widow benefits.

Eliminate the requirement that men who retire at age 62 must compute their average earnings by including years up to age 65 and thus lower their retirement benefits excessively.

No deduction from assistance payments for recipients whose incomes are so low that their Social Security benefits must be supplemented by public assistance. Congress took the first faltering steps in this direction when it enacted the recent benefit increase but this policy should be fully implemented in any future benefit increases.

No deduction from Social Security benefits for injured workers receiving workmen's compensation.

Extend full Medicare coverage to the disabled.

Include prescription drugs under Medicare.

Raise the earnings base used for determination of contributions and benefits to $9000 immediately and $15,000 in 1972, and, thereafter, adjusted in line with increases in wage levels.

Increase the general revenue contribution gradually to an amount equal to approximately one-third the total cost of the program.

The AFL-CIO urges Congress to show the same vigorous spirit it displayed in passing the higher 15 percent benefit increase against the opposition of the Administration. We call for enactment of meaningful and comprehensive Social Security legislation that will guarantee all elderly Americans a decent, comfortable living in their retirement years.

Report of Director, Health Insurance

(By James P. Deely)

To the Officers and Delegates of the Forty-Fifth National Convention held at Detroit, Michigan, August 14–20, 1966, *Greetings:*

I take pride in submitting to you the financial reports of the N.A.L.C. Health Benefits Plan for the years ended December 31, 1964 and December 31, 1965.

The reports show that the Plan is *not* making tremendous profits. They also show that the Plan is *not* accumulating extremely large reserves which would tend to make a balance sheet look good. Above all, however, they *do* show that the Plan is financially keeping its head above water.

It has always been the intention of your Board of Officers to formulate premium rates at amounts within the budget of a Letter Carrier which would allow the payment of adequate comprehensive benefits and establish reserves. I firmly believe that we have done just that.

Proposals to U.S. Civil Service Commission

As this report is being written, we are negotiating the 1967 contract with the U.S. Civil Service Commission.

Generally speaking, medical costs continue to rise and our Plan has not been an exception in bearing the brunt of the added costs. In line with our policy stated above, we have made the following proposals to the Commission:

1. Increase the first dollar coverage of Other Hospital Expenses for High Option from $800 to $1000;
2. Increase the calendar year maximum for Other Medical Benefits for High Option from $10,000 to $15,000; and
3. For High Option enrollment only, pay hospital maternity benefits the same as for an illness.
4. Allow benefits for services of Licensed Practical Nurses under certain well-defined circumstances under both options.
5. Recognize post-operative care by Podiatrists under both options.
6. Remove the "normal activities" provision of the hospital confinement definition. This means that the only restriction is the 3-month separation requirement for the same illness.

Pending legislation will add two additional benefits by Statute. The first increases the Government's contribution toward the total premium cost. The new contribution is as indicated below.

Also, the maximum age limit for unmarried dependent children would increase from age 21 to 22.

The Commission is also anxious that we increase benefits for mental disorders and as a consequence, our Actuary is now studying the matter.

The above package of added benefits plus a required minimum amount to keep the plan in continued solvency will mean an increase in premium costs. With the Government increasing its share of the over-all premium cost, the revised biweekly rates are as follows:

	High option	Low option
Self only:		
Total cost	$3.96	$2.76
Government pays	1.68	1.38
You pay	2.28	1.38
Self and family:		
Total cost	12.08	7.98
Government pays	4.10	3.99
You pay	7.98	3.99

The recommendations have been reviewed and approved by the Plan's Actuaries.

The Civil Service Commission has the authority, of course, to increase or decrease the above premium and benefits proposal.

Double coverage

Without the Double Coverage provision, which affects only a small minority of our membership, the above biweekly proposals would have to be raised upward a *minimum* of 23 cents for each family member.

To further illustrate the impact of the Double Coverage provision, 85% of the Plan's reserve under Public Law 86–832 represents cumulative savings under the provision.

Since only 2.7% of our membership is affected by the Double Coverage—and I might add *not* adversely affected since their covered incurred expenses are generally paid in full by both plans—the wisdom of the decision to keep this provision is apparent.

Shown below is a schedule reporting the results of the application of the Double Coverage provision.

N.A.L.C. HEALTH BENEFITS PLAN—SCHEDULE SHOWING RESULTS OF DOUBLE COVERAGE PROVISION FOR THE CONTRACT PERIOD NOV. 1, 1964, TO DEC. 31, 1965

	Public Law 86-382 (group)			Department RHB (nongroup)			
	High option	Low option	Total	High option	Low option	Total	Total both plans
1. Number of members on whose claims the double coverage provision was applied	2,081	532	2,613	39	26	65	2,678
2. Amount plan would have paid as contract allowance without the double coverage provision	$957,719.93	$193,970.92	$1,151,690.85	$12,963.24	$9,138.43	$22,101.67	$1,173,792.52
3. Actual payments after applying the double coverage provision	381,961.25	75,951.03	457,912.28	5,969.77	2,874.47	8,844.24	466,756.52
4. Amount of "savings" added to solvency of the plan	575,758.68	118,019.89	693,778.57	6,993.47	6,263.96	13,257.43	707,036.00
5. Average amount saved per member with double coverage			265.51			203.96	
6. Additional monthly increase in premium per family enrollment to eliminate the double coverage provision			.51			.44	

NOTES

The total number of members having double coverage under the group plan—2,613—represents 2.07 percent of the total enrollment; the 65 with double coverage under the nongroup conversion contracts represents 2.6 percent of the total nongroup enrollment.

Cumulative savings added to solvency of the plan since inception of double coverage on Nov. 1, 1961: (a) Group plan, $1,965,056.01; (b) nongroup plan $35,304.99; (c) Total $2,000,361.

Membership

Our enrollment reports submitted each calendar quarter to the U.S. Civil Service Commission have always shown an increase in membership. A schedule of the Plan's membership composition is shown below:

	Public Law 86-382	Nongroup
High option	103,672	1,543
Low option	25,739	1,229
RHB certificates		459
Certificates issued prior to June 30 1960		1,444
Total membership	129,411	4,675
Number of persons covered	480,821	8,345

Pending legislation extends the dependency age from attained age 21 to attained age 22. This means that the non-group membership will decrease by approximately 700.

Medicare

By reason of medicare, we anticipate a substantial switch of the retired membership from High Option to Low Option. This will no doubt be primarily due to the non-duplication of coverage provision made mandatory by the Civil Service Commission for each Plan participating under the Federal Employees Health Benefits Program.

The loss in income attendant to the anticipated transfer will be offset by the decrease in claim costs.

A questionnaire was sent to our non-group retired members eligible for Medicare to determine whether they wished to cancel our Plan in view of their Medicare eligibility and our non-duplication of Medicare coverage provision. The response was very surprising. Of 1,495 enrollees under the old plan, who were eligible by age (65) for Medicare, 273 elected to cancel their coverage with us, effective July 1, 1966. Another 41 elected to cancel their own coverage and change policy to wife only.

The non-duplication provision under our old Hospitalization Plan will mean that many types of expenses such as out-patient care and doctors' visits, not covered by the basic certificate, will be considered as covered expenses. This will mean that expenses covered by Medicare or the non-group certificate will generally be paid in full by both Medicare and our Plan.

Chiropractors

Our Actuaries opposed the inclusion of a "Chiropractor" in our definition of a "doctor" when the Plan was established in 1960. In an effort to make available as many practitioners as possible, we persuaded our professional consultants to accept our point of view. Chiropractic was recognized.

Almost from the inception of the program we encountered trouble with chiropractic claims. Expenses were submitted for X-rays that could not be interpreted, due to the poor technical quality of the films; claims were made for treatment of measles, mumps, heart trouble, mental retardation, female disorders and sundry other ailments. None of these conditions has any medical relationship to vertebral subluxations or spinal misalignments.

For the contract term beginning November 1, 1964, clarifying language relating to chiropractic was put in our brochure. The new language was not a change in benefits; it simply clarified the benefits allowable. Recognition of chiropractic was never intended to cover any expenses beyond spinal adjustments by hands of vertebral subluxations or misalignments. As is the case in all other types of claims, the Plan reserved the right to require X-rays to demonstrate the presence of the diagnosis.

In the interim, the problem became worse instead of better.

Early in December of 1964, several other employee organizations suggested we join them in a meeting with the national officers of the two major Chiropractic groups. On December 8–9, 1964, we did participate in a conference with leaders of The American Chiropractic Association and the International Chiropractors Association.

This meeting developed the interesting and significant fact that our problems with chiropractic were identical to those of the other participating plans.

After a frank and complete review of the situation, both associations issued bulletins to their respective membership. It is doubtful if anyone of the employee representatives could express the problem more clearly or succinctly than did the two Chiropractic associations.

The bulletin of the American Chiropractic Association stated:

"We were invited to the meeting to impress upon us the urgency and the need for adequate cost control to counteract the many claims abuses by members of our profession. We are amazed at the number of fantastic claims and cases which were shown to us to justify the urgency of the situation."

The International Chiropractors Association reported:

"It is no secret that most insurance carrier complaints stem from three major abuses: (1) Excessive charges; (2) Practices beyond analysis, X-ray and spinal adjustment, and (3) Prolonged care and excessive office calls."

The leaders of both ACA and ICA made repeated efforts to impress upon their membership the gravity of the situation, and the need to halt and prevent further abuses of insurance benefits. For reasons I cannot explain, these efforts produced no discernible improvement.

By mid-1965, we were convinced that it would be a greater disservice to our member to continue recognition of chiropractors than to eliminate them from our contract. If recognition continued, and the abuses also continued, the inevitable result would be financial disaster for many of our members. That is to say, some chiropractors would continue to furnish treatment for services not covered under the contract which, in turn, would result in the member literally "holding the bag" for incurred expenses that were not insurable, although the chiropractor would have every right to expect payment from the patient.

In commenting on this subject, one fact should be emphasized. It is a matter of record that we not only engage the professional services of disinterested medical consultants to interpret X-rays in dispute, but we also made the same X-rays (and related claim data) available to representatives of both chiropractic groups.

One incident will dramatize the problem confronting me as Director of our Plan.

At our invitation, representatives of both ACA and ICA met in our office with one of the most reputable radiologists in the area, whom we had engaged on a temporary consultant basis.

Our doctor (medical) presented 20 sets of X-rays that had been submitted by chiropractors. Each film was purported to show a subluxation; in several instances, four to six subluxations had been diagnosed in a single X-ray.

One after another, each film was placed in the view box. The chiropractic representatives, including a radiologist of their own selection, were invited to point out the subluxations. Not a single one was identified. Nor did the chiropractic representatives offer a solitary comment.

Effective January 1, 1966, the brochure was amended to delete a "Chiropractor" in the Plan's definition of a "doctor."

FACT SHEET—COVERAGE OF CHIROPRACTIC SERVICES BY THE MEDICARE PROGRAM

THE PROBLEM

Recently, there has been a well financed campaign by the Chiropractic Associations to make chiropractic services reimbursable under the Medicare law. At the present time, the Medicare definition of physician does not include doctors of chiropractic and thus all chiropractors in independent practice are excluded. Services of chiropractors are also excluded from coverage as "other therapeutic services" since Medicare approved hospitals and extended care facilities normally do not offer chiropractic services.

It is the universal feeling by health experts that chiropractors lack the proper training and background to diagnose and treat human disease. They feel that chiropractic practice constitutes a danger to good health care since the education of chiropractors is substandard and unscientific and that the theory on which treatment is based is medically unsound.

CHIROPRACTIC THEORY

The theory of "subluxation" is the basis for chiropractic care. A simple definition of subluxation would be "an incomplete or partial dislocation." Chiropractors maintain that subluxation because it interferes with normal

nerve function is the most significant causal factor in disease and that cures can be accomplished for practically any human illness by treatment of the spine to bring it back into alignment. Thus, though chiropractors concentrate on musculoskeletal problems, they consider themselves competent to treat a broad spectrum of diseases. Chiropractors maintain, for example, that conditions such as diabetes, heart trouble, tonsillitis and cancer can be cured by manipulating certain areas of the spinal column.

In over 70 years of existence, chiropractic theory has not demonstrated any scientific proof for the theory on which chiropractic practice rests. In fact, chiropractors ignore most of the scientific knowledge about health and medicine which has been painstakingly developed through the scientific process by careful study and objective research but, at the same time, undertake no basic research themselves. One of the leading critics of chiropractic theory is the American Medical Association but so are the physicians who served on the Committee for Health Care through Social Security and fought along side organized labor for enactment of Medicare and who have opposed the AMA on many issues. Though physicians are often divided on many issues, they are unified in their opposition to chiropractic theory and practice.

CHIROPRACTIC EDUCATION

Studies of chiropractic education have criticized the lack of inpatient hospital training, extremely low admission requirements for students, lack of adequate facilities and lack of national recognition by an accreditation body. There are 12 chiropractic schools in the United States at the present time. All but one (Palmer) require at least a high school diploma for admission but four of the schools require only a C average in high school. Not a single one of the chiropractic colleges enjoys accreditation by any recognized education accrediting body in the United States. The Palmer catalogue states no mandatory requirements for admission. Three of the chiropractic colleges now require 2 years of college for admission. Of course, many chiropractors practicing today received their degrees at a time when requirements were even less stringent than these. In fact, a number of chiropractors now practicing received their degrees by mail order. In contrast, 84 percent of students admitted to Medical schools have bachelor degrees or higher and about 91 percent have B averages or better in college. In addition, all of them must have had at least 3 years of pre-medical college training before entering medical school.

Presently, all chiropractic schools offer four year courses leading to a Doctor of Chiropractic Degree. The first half of the four year course deals largely with science subjects and some outpatient clinical practices are emphasized during the remaining two years. There is no inpatient or hospital training.

Medical schools also offer four year courses leading to a degree as a Doctor of Medicine. The first two years emphasize the basic sciences and the last two outpatient and inpatient training. In addition, all medical students are required to undergo a 12 month hospital internship followed by a one-to-five year residency before beginning independent practice.

Evaluative studies on chiropractic education have expressed grave doubts about the quality of faculty and subjects taught by chiropractic colleges. Many faculty members with only the Doctor of Chiropractic Degree teach a wide variety of subjects such as pathology, dermatology, neurology, opthalmology, chemistry, etc.—subjects in which they have no particular qualifications.

HEW RECOMMENDATION TO CONGRESS

The U.S Department of Health, Education and Welfare reported to Congress in January 1969, the findings of an independent unbiased study of chiropractic that had been ordered by Congress. This report stated:

"Chiropractic theory and practice are not based upon the body of knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment," and "therefore, it is recommended that chiropractic services not be covered in the Medicare program."

Nelson Cruikshank, retired former Director of the AFL-CIO Department of Social Security, was a member of the 18 member Committee that made the study and concurs fully with its recommendation regarding chiropractors. The American Public Health Association, a blue ribbon task force to study the problems of Medicaid and related programs, and the National Council of Senior Citizens have made similar recommendations.

OBJECTIONS TO COVERAGE OF CHIROPRACTIC SERVICES BY THE MEDICARE PROGRAM

1. Chiropractic theory and practice is contrary to accepted scientific knowledge relating to health and disease. If the basic theory is false, then logically chiropractic diagnosis of the causes of illness is unrelated to why a person is ill.

2. Regardless of the validity of its theory, the lack of depth and quality of chiropractic education inadequately prepares the practitioner to diagnose accurately and to render proper medical treatment.

3. Coverage of chiropractic services in the Medicare law would mean that high school graduates with only 4 years of subsequent chiropractic training of dubious quality will be assuming responsibility for the care and diagnosis of some of the most difficult problems in medicine—conditions which are often attended by symptoms in the spine but may be much more pervasive and serious.

4. Since chiropractors are not trained to recognize disease, they may undertake treatment which could delay a patient from seeing a qualified physician. Early diagnosis and treatment of many diseases such as cancer may mean the difference between life and death.

5. Many diseases respond to early treatment by certain drugs. Chiropractors are not trained to prescribe these drugs and, in fact, are prohibited by law from doing so in 38 States.

6. There are no legal barriers to prohibition of coverage of chiropractors in public programs such as Medicare. A federal court in 1965 held that since the chiropractic profession maintains that they are competent to treat a wide range of human illness, they can be required to meet the same standards of education and training as Doctors of Medicine. This decision was upheld by the U.S. Supreme Court in 1966.

RECOMMENDATION

Care of patients should only be entrusted to those who have a sound scientific knowledge of disease and whose experience and competence render them capable of diagnosing and treating patients by utilizing all the resources of modern medicine. Since neither chiropractic theory nor the quality of chiropractic education equip chiropractors to do this, the AFL–CIO opposes coverage of chiropractic services in the Medicare program.

The CHAIRMAN. Thank you very much, Mr. Biemiller.

I must absent myself a few minutes from this hearing, and I am going to turn the Chair over temporarily to Senator Anderson, who was your ally in the battle over the medicare bill down through the years.

Mr. BIEMILLER. A valuable ally and a valued friend.

The CHAIRMAN. Senator Anderson.

Senator ANDERSON. No questions.

Senator WILLIAMS. No questions.

Senator BENNETT. No questions.

Senator ANDERSON (presiding). Thank you very much, Mr. Biemiller.

Mr. BIEMILLER. Thank you, Mr. Chairman.

Senator ANDERSON. The next witnesses are from the New Mexico Foundation for Medical Care.

Dr. Boyden, I am certainly happy you are appearing today, because you have done a fine job in dealing with medical care problems in your own State.

STATEMENT OF DR. GEORGE M. BOYDEN, PRESIDENT, NEW MEXICO MEDICAL FOUNDATION FOR MEDICAL CARE; ACCOMPANIED BY DR. HUGH B. WOODWARD, MEMBER, BOARD OF DIRECTORS, NEW MEXICO FOUNDATION FOR MEDICAL CARE

Dr. BOYDEN. Thank you, Senator Anderson.

Mr. Chairman, I am George M. Boyden, M.D., of Albuquerque, N. Mex. I am here today representing the New Mexico Foundation for

Medical Care which I serve as president. I am medical director of Presbyterian Hospital Center in Albuquerque, N. Mex.

With me today is Hugh B. Woodward, M.D., who is the immediate past president of the New Mexico Medical Society, a member of the board of directors of the New Mexico Foundation for Medical Care and is in the private practice of internal medicine in Albuquerque, N. Mex.

I want to thank the committee for the opportunity to express our viewpoints on H.R. 17550. We consider this proposed legislation of vital interest to the citizens of the State of New Mexico; therefore, we welcome this privilege. We wish to confine our remarks to the provision for health maintenance organizations particularly as modified by the Bennett amendment.

Our position with reference to H.R. 17550 is that the encouragement of health maintenance organizations to function in the medicare program is too limiting in its scope and does not encompass the aspirations of the physicians in New Mexico.

New Mexico, being a rural, sparsely settled State, would be unable to qualify for the services provided in this act in a number of instances. However, the Bennett amendment removes the limitations of the provisions concerning health maintenance organizations in that it provides for the establishment of professional review organizations (PSRO). This amendment supports a wide choice of organizational alternatives that are not limited by specific program barriers. An outstanding example of professional review organizations as defined in the Bennett amendment is the New Mexico Foundation for Medical Care.

The New Mexico Foundation for Medical Care was organized by the New Mexico Medical Society to act on behalf of the doctors of medicine and doctors of osteopathy in the State of New Mexico in the management of health care systems. Management modalities such as utilization review, quality evaluation and cost control can most effectively be performed by the professional review to which the foundation is dedicated.

The foundation, organized by physicians, offers a means of monitoring all phases of health care services. Its flexibility is one of its virtues.

The application of recognized standards is of paramount importance to a foundation program. The development of standards of health care assures the highest quality of care to the recipient at a reasonable expense. The overriding factor of these standards is that they are developed by the actively practicing professional people for their use in the local area.

Standards are administered by the foundation peer review committees composed of practicing professionals and are used to identify cases that require further scrutiny by the professional review committee.

The standards are as much concerned with underutilization as with overutilization. A byproduct of the development and implementation of standards is the institution of continuing professional education programs.

One of the tools of a professional review committee is the profile system. There will be a profile which delineates all health services

received by the patient and a profile of all services rendered by each professional provider. These profiles provide a systematic means of highlighting patterns of care in professional encounters which may require further examinations by peer review committees.

The standards of care and the profile system help assure a review program which is objective and nondiscriminating with respect to providers of care. Because it is administered by professionals, the recipients are assured of high quality care as measured by professional judgment of medical need.

It is essential in order to enforce and update standards of service that the total claims processing be performed by the foundation. From this total claims processing program, the integrity of the profile system is maintained. From the same data system which produces the profiles under direction of professionals, community norms of practice are revealed and variations subjected to professional scrutiny.

The foundation enhances the free choice of physicians, hospital, pharmacy, and other providers of services. The performance of members and nonmembers of the foundation will be measured by the same criteria.

Appropriate appeal mechanisms will be developed by the foundation to assure all providers of care equal treatment without discrimination.

A foundation program need not be limited to the role of a professional standards review organization. Its scope and aspirations may be much broader.

The foundation provides a means of involving individual practitioners and groups of practitioners in large-scale prepayment experiments. Notation is made of the authorization of demonstration projects in the Bennett amendment. This section appears overly restrictive in limiting reimbursement amounts for demonstration projects to the per capita costs in the 12-month period prior to the effective date of the project. Preferably, some allowance should be made for inflation and increasing costs, over which the contractor has no direct control.

We do not project that the New Mexico Foundation for Medical Care will solve all health delivery problems; however, we are convinced that by the careful application of standards of care and close enforcement of these standards that the health care dollar and available health resources will be more efficiently utilized.

The New Mexico Medical Society developed the Foundation for Medical Care to be of service to the citizens of the State of New Mexico and we stand ready to serve at this moment. The obstacle to performing this service is the lack of funds to assist in the development of our programs so that we might respond to the need which is so clearly evident. We urge the committee to include a provision in H.R. 17550 for the granting of development funds to organizations demonstrating a capacity to act as we have outlined above.

Mr. Chairman, we thank you for this opportunity. Dr. Woodward and I will be delighted to answer any questions the committee may have.

Senator ANDERSON. You have made some comments on the Bennett amendment. Would you care to amplify them a little bit?

Dr. BOYDEN. Pardon me?

Senator ANDERSON. Would you care to amplify your comments on the Bennett amendment?

Dr. WOODWARD. I think I could respond to that, Senator Anderson.

The Bennett amendment, very appropriately, provides for the modalities of the review mechanism that our New Mexico Foundation is based upon, and we strongly support the Bennett amendment.

Senator ANDERSON. Thank you.

Senator Williams?

Senator WILLIAMS. No questions.

Senator ANDERSON. Senator Bennett.

Senator BENNETT. Thank you, Mr. Chairman.

I appreciate those kind words in favor of the amendment that I helped work out.

What do you think would happen if we did not have such a system of review and check on utilization?

Dr. WOODWARD. I think this review has to be carried out by someone. I think it is an essential element of any program, and, in our philosophy, the closer to the delivery of service this review can be carried out, the more attention there will be and the more directly related to the job at hand.

Senator BENNETT. Then, can you think of any other group that would be more effective and more appropriate as a basis for a review.

Dr. WOODWARD. I can answer that in a loud "No."

Senator BENNETT. Thank you very much.

Senator ANDERSON. I have a couple of questions that the staff will ask.

STAFF. Senator Anderson has a question here. Do you believe most doctors will cooperate with your foundation?

Dr. WOODWARD. During the past 18 months, I have discussed our New Mexico foundation in every county medical society. The authority to establish a foundation was granted by our house of delegates meeting in May, and the affirmative vote was 90 percent affirmative.

In discussing this with my associates throughout the State, I find that they are most supportive of this approach to the problems.

STAFF. The second question was: Do you think this program of on-going review can reduce medicare and medicaid costs and improve the quality of care?

Dr. WOODWARD. I think the improvement of quality is the emphasis of the product that can come from this approach to review mechanisms. The addition of physician review of the scope that we have defined will add some administrative costs, but the assurance of quality and the assurance of payment for needed services will, in the long run, allow us to use the health care dollar to the best advantage of the recipients.

Senator ANDERSON. Thank you very much. Thank you for your testimony.

Dr. Robert A. Chase.

STATEMENT OF DR. ROBERT A. CHASE, CHAIRMAN, COMMITTEE ON MEDICARE AND MEDICAID, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY CHARLES D. WOMER, DIRECTOR, YALE-NEW HAVEN HOSPITAL, AND DR. ROBERT STONE, DEAN, UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE

Dr. CHASE. Mr. Chairman, I am Dr. Robert A. Chase, chairman of department of surgery at Stanford University School of Medicine.

Sitting with me is Charles Womer, director, Yale-New Haven Hospital, and Robert Stone, dean, University of New Mexico School of Medicine.

I am testifying today as chairman of the Association of American Medical Colleges Committee on Medicare and Medicaid.

The association represents all of the Nation's 105 medical schools, 389 of our leading teaching hospitals, and 34 academic societies from both the basic sciences and clinical disciplines.

Teaching hospitals represent 6 percent of all hospitals but 21 percent of available acute hospital beds in the United States. Teaching hospitals handle 22 percent of hospitalized patients in the United States and run an occupancy rate of 82 percent which is higher than all hospitals of the American Hospital Association.

Because of this broad representation, I believe we can speak for the typical academic medical center which includes the medical school, the faculty, and the teaching hospital.

We are very pleased to present today the association's views on H.R. 17550, a bill amending the Social Security Act which, among other things, is designed to make improvements in the medicare and medicaid programs.

Prior to our comments and observations on specific provisions contained within that proposed legislation and its subsequent amendments, we would like to make a few general statements relating to the effects and implications which the medicare and medicaid programs have had on the Nation's academic medical centers.

First, we wish to state that we believe the medicare program has been successful in serving part of the purpose which the Congress intended. The aged people of the country have received needed care and, more importantly, they have had access to this care in a manner never before available to them.

There have been some discrepancies between congressional intent and actual effect of the SSA interpretation of the legislation in reimbursement to teaching medical centers. The variety of ways medical staffs in academic medical centers are organized to provide patient care does not always fit the federally established requirements for payment as specified in existing legislation. We believe it imperative to emphasize that the majority of medical schools and teaching hospitals in implementing the regulations did so in a manner which they believed to be in accord and consistent with the intent and spirit of Congress and the administration.

The prime purpose of the medicare and medicaid programs is to upgrade the health care provided to our indigent citizens as well as our elderly citizens, irrespective of their economic means. Since many

medicare and medicaid beneficiaries live in large, center-city areas with few, if any, family doctors, the people are dependent on municipal teaching hospitals for medical care. These institutions have been chronically underfinanced and the professional medical care provided has traditionally been through interns and residents. These physicians in programs of graduate specialty education were supervised to a variable degree either by medical school faculty or by physicians in private practice.

With the advent of medicare and medicaid, new patterns of care began to evolve in many urban teching hospitals. The availability of funds for medical care has provided both the incentive and the financial means for instituting a variety of new systems which more directly involve senior, attending physicians continuously in the care of patients individually or as regular members of the medical care team.

Officials in the Social Security Administration, Congressmen in the House Ways and Means Committee, and professionals in the field of medical care delivery seem to agree with us that team care as offered in the teaching centers is of highest quality. They also agree that such teaching hospitals offer the most intriguing possibilities for innovations in professional care coverage and reimbursement. Any system of remuneration which puts a premium on withholding patients from the teaching setting or precludes any deviation from the one-to-one, physician patient, fee-for-service system not only threatens the supply of well-trained specialists and hampers innovation in health care delivery, but it also deprives patients of some of the best medical care available.

It is in this spirit, Mr. Chairman, that we offer the following specific recommendations on specific items contained within H.R. 17550 and its amendments.

First, I would like to address myself, on behalf of our group, to section 226, "Payment for Services by Teaching Physicians Under the Medicare Program."

There has been widespread recognition of the diversity which exists with respect to the organizational and financial relationships regarding attending physicians in teaching settings. The nature of this understanding is amply documented in two recent congressional reports:

(1) The report of the staff of the Senate Finance Committee dated February 9, 1970, notes: "The staff is aware that the involvement of teaching physicians in direct patient care varies with respect to a given patient from none to extensive."

(2) The report of the Committee on Ways and Means which accompanied H.R. 17550 recognized and commented specifically on the "wide variety of teaching arrangements."

Additionally, the Department of Health, Education and Welfare comments on the Senate Finance Committee staff recommendations for changes in medicare and medicaid noted: "However, it may well also be appropriate to modify the medicare reimbursement provisions so that they are more responsive to the unique practices and policies of some of the teaching institutions."

In reimbursing the physicians' services in the teaching setting, the fundamental difficulty has been to develop appropriate criteria to

distinguish between a physician's teaching services which can be covered only under the hospital insurance program on a cost basis (part A) and his personal services to patients which can be reimbursed under the medical insurance program on a reasonable charge basis (part B). We believe the criteria for distinguishing between teaching and patient care needs to be responsive to the House Committee on ways and Means' acknowledged "wide variety of teaching settings" in which physicians both practice and teach simultaneously.

At one end of the continuum there is the teaching hospital with an almost exclusively charity clientele in which the treatment of the beneficiary may substantially be the responsibility of the house staff, that is, interns and residents; in such hopsitals some teaching physicians have traditionally had the exclusive role of teacher and supervisor. At the other extreme, there is the community hospital with a residency program which relies on the private patients of teaching physicians whose primary activity is private practice.

The pressure of private patient demands, as a reflection of sociological, organizational and technological changes, has required that practicing physicians who formerly had substantial time available for charity care now must spend more time in their own private practices. In essence, the voluntary faculty physician in the teaching setting has found it increasingly difficult to provide professional service to indigent patients without receiving some financial compensation. The effective utilization of the physician's time has become such an important factor in his continued fiscal solvency that he can no longer afford to give it away. Charitable institutions faced by rising costs from long overdue wage adjustments and inflationary pressures cannot afford to purchase the physician's professional services and then, in turn, to make these available free to their indigent clientele. However, institutions which have evolved modern management and accounting procedures, if they have the opportunity to obtain compensation for care provided to indigent patients can purchase professional services with which to provide the care. Adequate controls might be included to monitor for the indirect costs of this essential middleman activity.

The salaried faculty members similarly found that, because of increasing demands made by their responsibilities for administration and professional management, the demands for their time by house staff and students, the need to engage in productive research as a requisite of academic achievement, coupled with a serious lack of funds on the part of the institution to meet the level of salary necessary to recruit and maintain a properly qualified staff, it is necessary to recognize in their compensation time devoted to the care of the indigent patient.

Our recommendation is as follows:

We are very pleased, Mr. Chairman, to note that the House Ways and Means Committee in section 226 of H.R. 17550 addressed proposed legislation to the reimbursement of teaching physicians under the medicare program. We must emphasize, however, that due to the wide variety of teaching arrangements, we believe it is imperative that the Secretary be legislatively permitted to develop and implement several optional methods of reimbursing these physicians who simultaneously practice and teach. We believe that certain underlying principals

which would, among other things, insure that no institutional double billing is accomplished and that the medicare beneficiary receives a comparable level of care to that rendered by the physician to his other patients need to be legislatively reaffirmed. But we would urge for your consideration the proposal of options referred to above which we believe would provide for a resolution of the existing problems in the reimbursement of attending physicians in the various teaching settings.

We have appended to this testimony four such options. I will not read them at this point, but I would urge that the committee and staff seriously consider them. We would be most pleased to work with members of this committee and its staff to provide further clarification of these proposals.

It is once again, necessary to emphasize that the association believes that because of the variability of circumstances and situations in different teaching settings, each of these approaches should be legislatively permitted. Not one of the options should be considered as being preferentially endorsed by the association. It must be emphasized that each of these recommendations would, we believe, fulfill the intent of the law and would insure a high quality of care for each medicare beneficiary admitted to a teaching institution where the team approach to care is a hallmark.

We would be glad to answer questions as we go along, or we will address ourselves to a couple of other amendments that have emerged in this bill.

Senator ANDERSON. Go right ahead.

Mr. CHASE. I would like to address myself to the Bennett amendment in the legislation, Amendment No. 851.

This amendment provides that professional standards review organizations would be established in each area of the country with Secretary giving priority to designating qualified local medical societies as those review organizations. The on-going review, which these organizations would undertake, would involve maintenance and regular examination of the need, quality and efficiency of care given the beneficiaries. Additionally, the professional standards review organizations would be responsible for approval in advance of all elective admissions to hospitals and nursing homes. There would be additional review and a requirement or approval by the professional standards review organization where a physician desires that his patient remain in the hospital beyond the average stay established as norm for care of patients with specific illnesses.

We recommend the following:

Senator Bennett has suggested that his amendment might be further refined and improved on the basis of comment during these hearings, and we respectfully suggest that we support the principle but do suggest some changes in the substance of his amendment to cope with certain hypothetical and real problems that may arise as undesirable side effects of some details of the amendment as proposed. We are acutely sensitive to any detail in the designations and implementation of standards review organizations which may, in reality, interfere with delivery of efficient, economical, high quality care to beneficiaries as it attempts to assure just the opposite circumstance.

For example, in a teaching hospital where the mechanism for standards review already exists and is implicit in setting an example of care excellence, it seems reasonable to make use of it rather than to build an additional mechanism to carry out precisely the same task. Those of us who serve in teaching hospitals would welcome additional review and audit but to insist that it be prospective seriously would impede our efficiency in care delivery. At the very least, therefore, it would seem appropriate to allow institutions with such existing organizations for peer review the right to use this in-house mechanism to permit elective admissions by determining medical necessity, appropriateness of use of the facility and the assurance of service quality.

Patients arriving at teaching medical centers frequently come from a great distance, referred in by physicians who, for a variety of reasons, wish to have the patient receive care in such a center. If, after the patient is seen, admission for therapy is appropriate, such patients, under the best possible circumstances, may best be admitted on the spot. It is cumbersome, inefficient, and not in the best interest of quality care to delay admission for review and approval by an external body. It is unrealistic to expect that an external professional standards review organization could efficiently enough discharge such an obligation that it would avoid seriously impeding the patient's receipt of quality care.

Activities of such an in-house group ought regularly to be audited and reviewed to see that it abides by all of the standards and principles outlined under the norms of health care set by Senator Bennett's amendment. What I am suggesting might already be possible within the amendment as written.

In the amendment, section 1154(d) may be interpreted in a variety of ways, and I should like to clarify the intent of the paragraph.

Surely, there is no quarrel with the notion that duplication should be avoided. When the professional standards review organziation already exists and its performance equals or exceeds the standards set by the amendment, may the Secretary designate it as the PSRO, as provided for in 1152(B)(i)(E), "Such other public, nonprofit private or other agency or organization which the Secretary determines in accordance with criteria prescribed by him in regulations to be of professional competence and otherwise suitable?" I presume not, since (c)(1) gives clear priority to the nonprofit professional society.

Under this amendment, existing efficient PSRO's face obligatory replacement where a medical society exists. This, in fact, forces duplication of function in institutions which insist on standards exceeding those outlined in the amendment and which monitor care using their own review bodies. If it is the intent of the legislation to place constraints upon the Secretary by such strict priority rather than to allow him to designate the PSRO which he feels is most effective, the intent discriminates against organizations which have assumed greatest responsibility for standards control in some areas. I refer back to the testimony you just heard from the New Mexico Foundation for Medical Care. That is, obviously, a high quality group which does clearly fit the Bennett amendment quite nicely, and I think this would be an excellent PSRO group for New Mexico. The same thing

exists, it just so happens, in our own county, Santa Clara County, where there is also a foundation.

My concern is that the Secretary might be locked into a priority of choice to choose such a group or to set up such a group when, in fact, there may be an effective PSRO already in existence.

The other question I would like to pose for clarification is whether or not a group like this New Mexico group or any group from a county medical society could, in fact, delegate this responsibility to an in-house group or person.

I am concerned that the development of professional standards review organizations may not be responsive to the needs of medical centers which wish to experiment with innovations in delivery of services. Graded care, prophylactic measures, special less costly medical center hoptel development and use, and deviation from traditional reimbursement methods must not be impeded by a possibility biased group of nonteaching physicians making up the PSRO.

Finally, it is our view that the principle of peer review is appropriate, must be carefully worked out, but it must guard against review by individuals or institutions with a vested interest while, at the same time, it should not place decisive authority in the hands of individuals or groups who carry no legal responsibility for decisions affecting care of beneficiaries.

For example, in the event that elective admission is disallowed after it is recommended by a patient's physician and some complication arises attributable to lack of treatment by disallowance, the hospital is traditionally liable, not the medical society. Perhaps, this responsibility, as well as the authority, should be placed upon the review committee. It seems unreasonable to give the PSRO the authority and then cloak it with protection against legal recourse.

Shall I go on, or would you like to discuss them?

Senator BENNETT. Mr. Chairman, I would like to discuss it.

Dr. CHASE. Yes.

Senator BENNETT. I want to respond to you, but I think you have completely misread the Bennett amendment.

The Bennett amendment does not require the Secretary to appoint—first, the county medical society. It suggests that that may be a most appropriate thing to do, but it suggests alternatives.

I would think that if you had a situation in which a teaching hospital was the dominant medical group in a community or area, he might well appoint the staff of the teaching hospital as the basis of his peer review.

That is one comment.

Now, you used the word somewhere along the line——

Dr. CHASE. Senator, may I respond to that?

Senator BENNETT. Yes.

Dr. CHASE. That pleases me very much.

I have clearly misread the legislation. It is drawn from the following statement: In making such agreement, the Secretary would give, first, priority to the local medical societies or subsidiary organizations which represent a substantial portion of the physicians in the area.

Senator BENNETT. Maybe the word "priority" needs to be looked at. It does not mean that he is locked in. If there is a medical society,

he may find, in his opinion, it is incompetent or that there is a better alternative.

Also, I would think, as a pragmatic proposition, if, in a big teaching hospital, you had adequate internal review, the medical society or the peer review organization selected would be very happy to avoid the responsibility of duplicate review and probably occasional audit-type checks.

I am sure you can understand the fear that an in-house group like this might be inclined to be so defensive that they would support anything their members did against anybody from the outside. This has been part of the problem that generated this whole situation.

Dr. CHASE. I can understand that point of view very clearly, and none of our teaching hospitals would object in any way to a peer review. But the "R" in PSRO does stand for review not for prospective decisions, and it is our concern that perhips that a prospective decision might conceivably put the PSRO in a difficult position; that is, in the example that I mentioned, that a review by the PSRO, coming to a decision for nonadmission prospectively, could, conceivably, create legal complications for the PSRO itself.

Senator BENNETT. It is my understanding that we are not concerned with nonadmission; we are concerned with nonpayment, which is the same situation that an insurance company now finds itself in. The physician can go ahead and admit his patient, without any question, but there may be a question as to whether, under the laws or under the rules, this service should be paid for by the system.

Dr. CHASE. Sir, I would like to ask Charles Womer, if, under circumstances like this, where a physician made a decision to admit the patient, the hypothetical situation which is unlikely to occur but it may, where a physician has made a decision for admission, the PSRO disqualifies that admission, what would be the stand of the hospital administration, and who would be responsible for reimbursement of the hospital under the circumstances?

May I ask you that, Charlie?

Mr. WOMER. We will have to bill the patient.

Senator BENNETT. That is right.

Mr. WOMER. I am also concerned, as Dr. Chase has mentioned that many of our teaching hospitals operate as regional referral centers, and a good many patients come from outside the local area.

To require the advance approval of a PSRO for a patient who is traveling 50 miles, 100 miles, to come to the hospital, to see his physician to whom he is referred, who, then, wants him admitted, but you have to send the patient home again until you get PSRO approval, that seems to place an unnecessary burden and cost on the patient.

Dr. CHASE. I would amplify that by saying that that problem would be solved quite nicely with what Senator Bennett has said, that that could be delegated, at least, to an in-house review body by the PSRO, no matter what the designation of the PSRO was.

Senator BENNETT. Yes, subject to some kind of an audit.

Dr. CHASE. Right.

Senator BENNETT. But I understand the State of California is going to require that kind of a review on all Medicaid patients after the first of the year.

Dr. CHASE. That is correct; yes, sir.

Senator BENNETT. So, you already have the problem.

Dr. CHASE. But the source of the appointment to the PSRO has not been clearly determined.

Senator BENNETT. It is my impression that the language will give the Secretary sufficient latitude. Take my State of Utah. We probably have only three counties in the State where there is a medical group large enough to form the basis of a PSRO and probably the State medical association will step in to review activities in the other counties. In order to do that, in terms of distance and time, you have to have latitude. I do not think the intention of the legislation is to be very rigid. It is to make it possible to get adequate review and to prevent the kind of situation that we have had from time to time.

Dr. CHASE. I am comforted by your statement, Senator. I would say, I would emphasize again, that we clearly agree with the principles of the Bennett amendment, and we are only haggling over some details of administrative management.

Senator BENNETT. Thank you.

Dr. CHASE. May I go on, Senator?

May I go on to other remarks?

Senator ANDERSON. We have a long program today.

Dr. CHASE. Yes. We have written the testimony concerning section 222 and 239, and if you would prefer that we present it to you in writing, that will be fine with us.

Senator BENNETT. It is just as effective.

Dr. CHASE. Thank you, sir.

(The comments of Dr. Chase on sections 222 and 239 follow:)

SECTION 222 EXPERIMENTS AND DEMONSTRATION PROJECTS IN PROSPECTIVE REIMBURSEMENT AND TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

This section of the bill includes authorization for the Secretary to engage in experiments and demonstration projects involving negotiated rates, the use of rates established by a State for administration of one or more of its laws for payment or reimbursement to health facilities located in such states. We were particularly grateful to note that the Report accompanying H.R. 17550 made specific mention that this section of the amendment will permit experimentation in "alternative methods of reimbursement with respect to the services of residents, interns, and supervisory physicians in teaching settings."

As we have previously testified before this Committee's Subcommittee on Medicare and Medicaid, we believe this increased authority to be imperative. In testimony of June 3rd, before that Subcommittee, we stated, "One area that shows particular promise for strengthening this access point lies in experimentation and innovation with methods of delivery of medical care, specifically with regard to the provision and reimbursement of surgical or medical services in a teaching setting." As we understand it, this section of the amendment does provide this. We are concerned, however, about another feature incorporated within this amendment which provides that such experiments and demonstration projects may be initiated only after the Secretary obtains the advice of specialists and after a written report containing a full and complete description of each project has been submitted to the House Ways and Means Committee and the Senate Finance Committee.

RECOMMENDATION

We would recommend that because of the very nature of experiments and demonstrations and the fact that they usually require a limited financial outlay that they not be impeded by burdensome and restrictive approval requirements. The establishment of a system of annual reports by the Secretary of the House Ways and Means Committee and the Senate Finance Committee should suffice to keep these committees and Congress fully informed.

SECTION 239—PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

This section would amend the existing law to permit the Medicare beneficiary to have a choice of continuing under the present Part A and B arrangements or electing the option to receive their health care through a health maintenance organization. Under such health maintenance organization each enrollee would receive a guarantee that all services covered under Parts A and B of Medicare, plus preventive services will be available. The amendment provides for a health maintenance contract calling for payment of a fixed annual sum negotiated in ordinance at a price less than the government presently pays for Medicare benefits in the locality.

RECOMMENDED POSITION

The AAMC is extremely concerned about the following features of this proposal:

1. There is a serious omission in terms of funding the developmental or "risk" financing in support of the establishment of such organizations. Evidence, which has been generated in those medical centers that have undertaken such activities indicates that the initial "start-up" costs of such programs are very substantial and well beyond the capability of the medical center itself to underwrite.
2. The reimbursement proposal indicates that payment from Medicare, for services rendered to beneficiaries would not only be directly negotiated, but that they would be based on average payments made uder Part A and B. We believe that with the development of a system of geographic "averaging" of costs, it is very doubtful that an equitable pattern of reimbursement to teaching hospitals can be obtained.

(It does not have an average patient population—emphasis on costly complicated serious care problems.)

Senator ANDERSON. Dr. Wurzel, go right ahead.

STATEMENT OF DR. EDWARD M. WURZEL, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF MEDICAL CLINICS

Dr. WURZEL. Mr. Chairman and members of the committee, I am grateful for this opportunity to provide this testimony.

I am Edward M. Wurzel, the executive director of the American Association of Medical Clinics, with headquarters in Alexandria, Va.

The American Association of Medical Clinics is a voluntary, nonprofit professional association representing approximately 10,000 physicians in 250 group practices located in 41 States; there is one Canadian member clinic. AAMC members treat about 17 million patients annually.

The association was formed in 1949. Its objectives include elevating the standards of medical practice in clinics, improving graduate education and research in medical group practices, increasing scientific knowledge relating to group practice, and providing two-way communications between the legislators and regulators in the health field and the physicians and other professionals engaged in the group practice of medicine. AAMC maintains an accreditation program, publishes a monthly journal, Group Practice, an annual directory and topical bulletins as indicated, sponsors national and regional conventions, has an associated research foundation, and supports 17 committees in fields of appropriate interests. The association is currently deeply involved in many efforts designed to improve the health care delivery system.

AAMC member clinics fall into four categories of membership, ranging in size from three physicians to over 1,300 physicians. It includes medical centers renowned for their clinical excellence, their research contributions and their teaching record. The world's largest

center for postgraduate medical education is a member as are both the largest prepaid and fee-for-service group practices in the country. The majority of members are multispecialty, fee-for-service groups but there are also single specialty groups, prepaid groups and some groups that combine fee-for-service and prepayment. Many of these groups were organized fifty or more years ago. Their composite experience represents a most noteworthy, naturally occurring experiment in the history of health care delivery. They have solved a multitude of organizational problems and made significant contributions to both the science of medicine and the distribution of health care.

The testimony of this association today concerns only that section of H.R. 17550 dealing with health maintenance organizations, since this is the area where we have unique experience.

After careful consideration the American Association of Medical Clinics has concluded that the HMO concept should be strongly supported.

The HMO is judged to be a a highly desirable method of aiding the health care delivery system to make full use of the scientific, technical, social, political, economic, and administrative forces available to it.

With such full utilization, present deficiencies in the system can be eliminated. The improved system which can be developed is expected to supply health care services high in quality and sufficient in quantity to meet the needs of society. Furthermore, these services can be available when and where needed, provided in a manner acceptable to the recipient, at a cost that is reasonable.

It is not our contention that these benefits can be expected from HMO's alone. Rather, in our judgment the HMO will serve not only as a catalyst but more importantly will provide a continuing source of both energy and guidance to stimulate appropriate elements in the professions involved: Stimulate them to healthy competition, to wise innovation, to continuing evaluation and to adopt demonstrated improvements as they develop.

HMO's provide for both public and private efforts and in the judgment of AAMC this is a critical virtue. The role of private enterprise in the health care system must be preserved. And just as importantly the role of public or government efforts must be recognized. Better definition of these roles with constant reevaluation and adjustment is needed. While the present legislation does not address this problem directly, it will provide data and stimulation for subsequent legislation.

AAMC interprets the HMO proposal as a sincere invitation to those now engaged in delivering health care to participate in planning and executing the shape of their profession for the future. This is a most important aspect of the plan. HMO's insure wise and rapid improvements in the system because changes will be directed by trained professionals with actual experience in the delivery system. On the other hand, it does not preclude the possibility that unconventional approaches might lead to significant improvements. It assures the benefits of evolution but does not preclude the possible advantages of some revolutionary approaches. The main body of the present delivery system will be protected and its evolution stimulated, but a number of unorthodox systems can be tested.

This flexibility and broad capacity to accommodate a large variety of patterns for the delivery system is one of the critical strengths of

the HMO concept. It provides an excellent framework within which physicians and their colleagues on the health care team can evolve a better system to provide adequate high quality care, where and when needed, acceptable to the recipient and at a reasonable cost. It provides appropriate roles for experienced health care professionals to participate in both the planning and the delivery of health care as either a private or a public function. It assures that the current system will not be scrapped before a better one is available but yet encourages bold experiments to achieve stated goals. It provides for multiple approaches avoiding the dangers of creating a monolithic monster. It provides for participation by local as well as Federal Government.

That these are the criteria of a good system in the judgment of this association can be judged from a recent editorial in our journal which included under the title, "A Credo for Our Times . . .", the following, and since you gentlemen have this, I will not take the time to read our credo, but I will continue.

Convinced as we are of its overall value, we would like to share with the committee some of the dangers in the HMO concept which we evaluated before reaching our present position of strong support. We considered the general effects of HMO's on quality and costs of health care and the specific problems HMO's posed for our members in matters of patient referral and the cost of out-of-area coverage and major medical liabilities. I will attempt very briefly to state our considerations and conclusions.

QUALITY OF CARE

This association has valuable experience in defining and evaluating the quality of health care. Standing committees on both professional standards and credentials have been active since the association was founded. More than 15 years were spent in developing an accreditation program which is now entering its third year of operation. Our studies and experience show that there is no single more important factor in assuring high quality health care than the education and ethics of those providing and guiding the care. We are confident that adequate safeguards will be included in the legislation and subsequent regulation to guarantee that only properly trained professionals with unquestionable ethics will participate in these programs.

AAMC relies upon the wisdom of government to utilize the resources of established national organizations with capabilities and experience in reviewing and certifying health care activities to prevent any loss of quality in the HMO. In addition to techniques for evaluating the qualifications of the individuals providing health care, AAMC has established methods for assessing other evaluators of the quality of health service; these include audit and peer review, study of the health record, direct and indirect observation, study of diagnostic and therapeutic practices both theoretically and by consideration of their end results. These techniques and services are available to those who will be concerned with assuring that only high quality health care will be provided through HMO's.

The possible bias toward lessened quality which some fear may be fostered by the prepaid aspect of HMO's was considered but ruled out. In the first place it has not occurred in the existing high quality pre-

paid group practices. Further, the constant peer review and high visibility of professional activities inherent in properly supervised group practices militate against any fall off in quality. Finally, the existence of effective evaluating techniques mentioned before will quickly reveal any quality defects that might develop.

COSTS

Accreditation of a group practice by this association is granted if it is adjudged to meet the program's high standards in each of four categories. These categories are quality of services provided, the degree to which the potential benefits of group practice are achieved, the most effectiveness of the group's activities, and the absence of any practice which might tend toward patient exploitation. Thus we have a wealth of experience on the costs of health care in group practice and its comparison with costs of other modes of delivering health care. This experience shows that the dollar costs per visit per patient are approximately equal in group practice and solo practice but that the services provided per dollar cost are significantly higher in group practice. At this point we are justified in assuming that the group practice element of the HMO decrease service cost. The effect of the prepaid mode on costs should be to further lower them by allowing the HMO to provide services to the ambulatory patient for which he is now being hospitalized. This source of saving is considered both certain and significant.

It remains to be demonstrated what other sources of savings may result from prepayment. However, the two sources mentioned above are not inconsiderable.

The possibility that costs to the Government will be raised by driving high risk and/or high user patients out of the HMO, thus raising the extra HMO costs on which HMO renumeration is figured and giving the HMO more money for less work, is considered very unlikely. Statistically, there is little evidence that wide variations of use exist for large numbers of users. The same forces would have acted in currently operative prepaid groups but have not appeared. An overt act on the part of an HMO to profit by such a device would be unethical and so visible that it would not be countenanced. The entire argument is considered ingenious but unconvincing.

Senator BENNETT. I wonder if Dr. Wurzel would consider putting the rest of his statement in the record. He has already talked nearly 20 minutes, and we have about six more witnesses.

Dr. WURZEL. I wonder if I could be allowed to just make the point about referrals, which is important to us.

Senator BENNETT. Well, can you make it short, two or three pages?

Dr. WURZEL. I will indeed. I will make it as short as I can.

We believe that the current law will militate against prereferrals because the HMO will have to pay for the cost of referral. We think this has a tendency to deprive the patient of necessary referrals, and also to dry up the source of patients upon which our great referral centers depend, and we think this a defect in the law that has to be remedied.

Senator ANDERSON. Thank you very much, Doctor. Are there any further questions?

(The prepared statement of Dr. Wurzel follows. Hearing continues on p. 475.)

STATEMENT BY EDWARD M. WURZEL, M.D., EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF MEDICAL CLINICS

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I will not take further time before this committee to provide additional details about the Association; I believe that most of the members are already familiar with it. I am, however, attaching a Directory of the Association to the original of this report for the benefit of those who may wish to see the distribution of our membership and the organization for medical care delivery within the clinics represented.

The testimony of this Association today concerns only that section of H.R. 17550 dealing with Health Maintenance Organizations, since this is the area where we have unique experience.

After careful consideration the American Association of Medical Clinics has concluded that the HMO concept should be strongly supported.

The HMO is judged to be a highly desirable method of aiding the health care delivery system to make full use of the scientific, technical, social, political, economic, and administrative forces available to it.

With such full utilization, present deficiencies in the system can be eliminated. The improved system which can be developed is expected to supply health care services high in quality and sufficient in quantity to meet the needs of society. Furthermore these services can be available when and where needed, provided in a manner acceptable to the recipient, at a cost that is reasonable.

It is not our contention that these benefits can be expected from HMOs alone. Rather in our judgment the HMO will serve not only as a catalyst but more importantly will provide a continuing source of both energy and guidance to stimulate appropriate elements in the professions involved: Stimulate them to healthy competition, to wise innovation, to continuing evaluation and to adopt demonstrated improvements as they develop.

HMOs provide for both public and private efforts and in the judgment of AAMC this is a critical virtue. The role of private enterprise in the health care system must be preserved. And just as importantly the role of public or government efforts must be recognized. Better definition of these roles with constant reevaluation and adjustment is needed. While the present legislation does not address this problem directly it will provide data and stimulation for subsequent legislation.

AAMC interprets the HMO proposal as a sincere invitation to those now engaged in delivering health care to participate in planning and executing the shape of their profession for the future. This is a most important aspect of the plan. HMOs will insure wise and rapid improvements in the system because changes will be directed by trained professionals with actual experience in the delivery system. On the other hand, it does not preclude the possibility that unconventional approaches might lead to significant improvements. It assures the benefits of evolution but does not preclude the possible advantages of some revolutionary approaches. The main body of the present delivery system will be protected and its evolution stimulated, but a number of unorthodox systems can be tested.

This flexibility and broad capacity to accommodate a large variety of patterns for the delivery system is one of the critical strengths of the HMO concept. It provides an excellent framework within which physicians and their colleagues on the health care team can evolve a better system to provide adequate high quality care, where and when needed, acceptable to the recipient, and at a reasonable cost. It provides appropriate roles for experienced health care professionals to participate in both the planning and the delivery of health care as either a private or a public function. It assures that the current system will not be scrapped before a better one is available but yet encourages bold experiments to achieve stated goals. It provides for multiple approaches avoiding the dangers of creating a monolithic monster. It provides for participation by local as well as federal government.

That these are the criteria of a good system in the judgment of this Association can be judged from a recent editorial in our Journal which included under the title "*A Credo for Our Times . . .*", the following:

We believe traditional private enterprise should be preserved in our country's health care delivery system. We support the appropriate incentives which are a part of private enterprise, realizing that some controls are necessary in a profit system to prevent abuses and protect consumers.

We believe appropriate roles should be assigned to a significant number of appropriate professionals—those with experience in the delivery of health care—when changes are being planned in the current health care delivery system. Membership in health care delivery planning groups of those whose only qualifications are the listing of destructive criticisms in the present system should be limited.

We believe changes in the present system of health care delivery should be based on an evolution out of the present system rather than abandonment and destruction of the present system.

We believe we should always see multiple solutions to changes in the health care delivery system to accommodate the varying conditions in different parts of the country and the different attitudes that characterize people geographically distant from each other. Single solutions should be avoided as being dangerous oversimplification, and—above all—single sentence definitions of the problems of the health care delivery system should be rejected as inadequate for so complicated a problem.

We believe Government participation in the solution to problems of the health care delivery system should, as needed, originate at the most local political unit possible for effectiveness, and Federal control should be avoided as much as possible to achieve successful local participation.

Convinced as we are of its overall value, we would like to share with the Committee some of the dangers in the HMO concept which we evaluated before reaching our present position of strong support. We considered the general effects of HMOs on quality and costs of health care and the specific problems HMOs posed for our members in matters of patient referral and the costs of out-of-area coverage and major medical liabilities. I will attempt very briefly to state our considerations and conclusions.

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The possibility that costs to the government will be raised by driving high risk and or high user patients out of the HMO, thus rasing the extra-HMO costs on which HMO remuneration is figured and giving the HMO more money for less work, is considered very unlikely. Statistically there is little evidence that wide variations of use exist for large numbers of users. The same forces would have acted in currently operative prepaid groups but have not appeared. An overt act on the part of an HMO to profit by such a device would be unethical and so visible that it would not be countenanced. The entire argument is considered ingenious but unconvincing.

REFERRALS

In its present form the legislation would require the HMO to pay the cost of referral services for its patients, thus discouraging the proper use of referral patterns. This will deny the patient an important and frequently life saving service. Of equal or greater importance is the disastrous implication for the health care delivery system if this restriction on referrals is not eliminated from the bill. Freely available and readily accessible primary medical care for all cannot be provided unless we preserve our great referral and teaching centers. The extraordinary diagnostic and therapeutic skills available in these centers cannot be duplicated even in the high quality primary care centers envisioned for the HMO. There must be second and third lines of defense supporting the HMO to assure that the level of care available to its patients will be adequate to their needs when these needs are beyond the skills that can be or should be obtainable in the HMO. To acquire and maintain these highest degrees of excellence requires financial support, public approval and a continual flow of referral

patients to maintain and improve skills and allow for teaching the professionals so sorely needed by the system.

That aspect of the bill which operates to interfere with referrals is a serious defect which must be removed. More than this, the legislation should contain positive guarantees to assure that the country's great referral centers will not deteriorate for lack of patient referrals. Without this change the legislation could do more harm than good.

OUT OF ORGANIZATION COSTS AND EXTRAORDINARY MEDICAL EXPENSES

The requirement that the HMO pay the costs of health care delivered outside the organization (plan-jumping), can be a serious deterrent to acceptance of the concept. It introduces an element of unpredictable cost and possible abuse which concerns our members. The same is true for such extraordinary medical expenses as organ transplants or dialysis.

It is suggested that referral costs, exceptional out-of-organization costs and extraordinary medical costs * be financed through an insurance mechanism to be developed by the private and public agencies who will be cooperating in implementing this legislation. AAMC has developed basic proposals on this matter, and would be pleased to present them at the appropriate time and place.

Summing up, the position of this Association and its member clinics on the HMO proposal is not a unanimous one, and probably should not be expected to be. Several of our members have expressed strong doubts about the legislation; two of the most recent objections came just this past week-end from members who attended a Health Insurance Bureau Advisory Committee meeting in Baltimore, and heard for the first time some of the projected plans for regulation of the HMO operation.

However, our endorsement of the HMO concept does represent the official policy of this Association (as expressed by the Officers and Board of Trustees at the policy-making level), the feelings of a substantial majority of the individual members of the Association, and my personal opinion as Executive Director. We have high hopes that the problem areas I have just outlined can be successfully controlled or eliminated, that the concerns of some of our members about excessive or unwise regulation will prove to be unfounded, and that the establishment of the HMO program will fulfill its potential as a significant milestone in the evolution of an improved health care delivery system.

STATEMENT OF DR. ERNEST SAWARD, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA; ACCOMPANIED BY JAMES BRINDLE, CHAIRMAN OF THE BOARD AND DR. W. P. REARING, EXECUTIVE DIRECTOR

Dr. SAWARD. Mr. Chairman and members of the committee, I am Dr. Ernest Saward, president of the Group Health Association of America and associate dean of the University of Rochester School of Medicine.

Prior to this activity I was engaged in the active practice of internal medicine, and for more than 25 years was medical director of the Permanente Clinic, which was with the medical group which provided professional services to members of the Kaiser Foundation Health Plan, Portland, Oreg.

With me is Mr. James Brindle, the chairman of the board of Group Health Association of America, and president of the Health Insurance Plan of Greater New York (HIP); and Dr. Palmer Dearing, the executive director of Group Health Association of America.

The Group Health Association of America is a nonprofit organization dedicated to the accessibility, efficiency, and quality of medical care

*This proposal will not increase total program costs. It will spread the risks involved. As a dividend it will contribute to medical education in a critical area.

available to the people of the United States. It is the national association for group practice prepayment plans in the United States.

The Group Health Association of America works for the establishment and expansion of group practice prepayment plans which provide or arrange direct health care services for their members on an organized basis.

In recent years these plans have demonstrated that capitation arrangements can be used effectively in providing medical care in the Government programs. They participate successfully in the Federal employees health benefit program, and also provide medical care for thousands of medicare beneficiaries who are members of group practice plans.

Group practice prepayment plans have suggested on a number of occasions that the Social Security Act should be mended to permit such plans to receive combined per capita payment for both part A and B services.

Group practice prepayment plans have also undertaken care of poverty populations successfully on a capitation basis.

To conserve your time we offer an abbreviated summary of our written statement. The statement of the group practice prepayment organizations in relationship to the health maintenance organizations is that, first, we give strong recognition to the need for organized systems of health care in the United States.

Secondly, we appreciate and support an effort to use medicare dollars to improve the organization of health care services rather than applying them to reinforce the present unorganized approach toward health care.

However, because of certain provisions of H.R. 17550, the proposal must be amended to provide for continuation of per capita—nonfee-for-service—reimbursement to group practice prepayment plans for part B services for the following categories of medicare beneficiaries.

1. When beneficiaries who are entitled to benefits under both parts, A and B of medicare, do not elect the HMO option.

2. When beneficiaries who are part B beneficiaries do not qualify under part A.

Further, the Secretary should be directed to:

One, evaluate the performance of health maintenance organizations periodically.

Two, separately evaluate the performance of the general categories of plans which have substantial differences, such as group practice prepayment plans, and individual practice prepayment plans, often known as foundation plans.

Further, the beneficiaries should be given an immediate incentive to select the HMO option, such as having additional benefits to supplement their medicare coverage; and to reduce costs to them of the benefits supplementing their medicare coverage.

Three, there should be a clear and continuing incentive for the establishment of health maintenance organizations, including assurance of 95 percent of the average payment in the area.

The full statement contains a number of technical amendments which would clarify and improve the health maintenance organization provisions of H. 17550, and are recommended for adoption.

I will be glad to answer any questions.

(Attachments to Mr. Saward's statement follow. Hearing continues on p. 481.)

Re: A Potential Barrier to Participation of Existing Group Practice Prepayment Plans in the HMO Option

This memorandum discusses the problems with regard to reimbursement of group practice prepayment plans for members who are Medicare beneficiaries but cannot or do not elect to participate in the HMO option.

The following provisions of the health maintenance organization amendment to the Social Security Act as passed by the House of Representatives are relevant to this issue:

(1) Sec. 1876(d) provides that only individuals entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B shall be eligible to enroll with a health maintenance organization:

(2) Sec. 1876(d) and (e) both indicate that each eligible Medicare beneficiary has the option to enroll or not to enroll in a health maintenance organization;

(3) Sec. 1876(c)(2) states that an individual who enrolls in a health maintenance organization must obtain his Medicare services from the health maintenance organization with the exception of certain emergency services which will be defined in the regulations; and

(4) Sec. 239(c) provides that "notwithstanding the provisions of section 1833 of the Social Security Act, any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of such Act shall, for the duration of such agreement, be entitled to reimbursement only as provided in section 1876 of such Act."

As now drafted, the HMO provision would apply only to Medicare beneficaries who meet the following requirements:

(1) They must be eligible for Part A*;
(2) They must be enrolled in part B of Medicare; and
(3) They must affirmatively elect the HMO option.

When a beneficiary elect the HMO option, he gives up his right to be reimbursed by Medicare when he seeks care from other sources except for certain emergency services. When a plan enters into a health maintenance organization agreement with the Secretary, it gives up its right to be reimbursed by Medicare in any other manner.

A number of group practice prepayment plans, including Kaiser Foundation Health Plan, provide coverage for members who are Medicare beneficiaries. Hospital based group practice prepayment plans are reimbursed for members who are part A beneficiaries on the same basis as other providers of part A services. However, most group practice prepayment plans are reimbursed for members who are part B beneficiaries on a per capita basis under a method which has been worked out administratively with the Social Security Administration. Our fundamental objective is to have satisfactory arrangements for being reimbursed for members of our plan who are part B beneficiaries and for whatever reason do not come within the HMO option on a non-fee-for-service basis. The operations of group practice prepayment plans and the relationship between such plans and their members who are Medicare beneficiaries should not be disrupted by forcing such plans to either terminate a substantial number of members or arrange services for them on a fee-for-service basis.

You requested a description of the major categories of Medicare beneficiaries who would be excluded from the HMO option. The following brief and perhaps not meticulously accurate, summary covers the major categories:

(1) Persons not eligible for part A. The following are the most significant groups of persons who are not entitled to part A of Medicare:

(a) Persons who have spent their careers in the Federal civil service and have consequently not had Social Security covered employment.

(b) Persons who have spent their careers in civil service in some states and political subdivisions of some states that have followed the Federal pattern

*We do not regard the opportunity to "buy in" to part A at $27 per month to be a realistic solution for most Medicare beneficiaries. In fact, even though the cost of part A coverage within the Kaiser Foundation Medical Care Program is substantially less than $20 per month, we have considered this to be an excessive amount for an individual Medicare beneficiary to pay and beneficiaries not enrolled in part A have been supported by their group or, in the case of individual subscribers, by the plan subject to the same limited loading applied to subscribers who do not enroll in part B.

of non-participation in the Social Security system, or such persons who, when given an opportunity, did not elect Social Security coverage.

(c) Persons not eligible for part A because they lack the required number of calendar quarters of Social Security covered employment or self-employment. This group will increase in numbers under the present law as the number of quarters of coverage required for part A eligibility increases. (This category actually includes the persons described in paragraphs (a) and (b) above.)

(2) Persons not enrolled in part B. For practical purposes everyone who is eligible under part A may voluntarily enroll in part B and, in addition, persons not eligible for part A in the categories described above may still enroll voluntarily in part B; however, because part B enrollment is voluntary and requires a $5.30 monthly payment and because of problems of communication and human inertia, there are a considerable number of persons in the over-65 population who are not enrolled in part B. The following are major examples:

(a) Federal civil servants and other government employees not eligible for part A (paragraphs (1)(a) and (b) above) who are covered by substantial health benefits programs which include coverage for annuitants have very little reason to enroll in part B. (However, some of them do enroll.)

(b) Some non-governmental health benefits programs include substantial coverage for annuitants and a number of retired workers covered by such programs have elected not to enroll in part B.

(c) In addition to the above categories which may have involved carefully considered decisions against enrolling in part B, there are a number of persons in the over-65 population who do not have adequate health coverage and are still not enrolled in part B—perhaps because they feel they can't afford it, or because they have not really thought it through, or for any number of human reasons.

(3) Persons entitled to benefits under part A and part B who do not elect the HMO option. We can only speculate about this class of individuals; however, the following comments may be of value in determining what is likely to happen:

(a) Even if the reasons for electing the HMO option were to be quite compelling, our experience with Medicare to date indicates that a significant number of eligible persons will not take the required affirmative action to elect this option due to difficulties of communication, inadequate understanding of the implications, human inertia or human irrationality.

(b) Considering the health maintenance organization provisions enacted by the House of Representatives, we do not see a compelling advantage to Medicare beneficiaries to enroll in the HMO option. (Why would attentive and thoughtful eligible beneficiaries elect the HMO option?)

We vigorously support the concept of a combined per capita payment for part A and part B of Medicare to qualified organizations which is a key feature of the HMO proposal. However, we believe that it would be disruptive to our program if this proposed legislation were to be enacted in a form which would preclude qualified group practice prepayment programs from continuing to serve all of their over-65 members on a non-fee-for-service basis with respect to part B services. Ideally, provision should also be made for serving members entitled to part A, who are not in the HMO option, on a non-fee-for-service basis.

From our viewpoint the minimum requirement, if group practice prepayment plans now being reimbursed by the Social Security Administration on a per capita basis for part B services and their members who are enrolled in part B of Medicare are to be treated fairly and equitably, would be to permit such plans to continue to be reimbursed on a per capita basis under section 1833 for their members enrolled in part B who cannot or do not elect the HMO option.

This Exhibit was attached to a letter addressed to Dr. Roger Egeberg, Assistant Secretary for Health and Scientific Affairs, from the Kaiser Foundation Health Plan dated July 1, 1970.

Proposed Amendments to H.R. 17550

Health Maintenance Organizations

A satisfactory solution of the problem that the first amendment is concerned with is absolutely essential to group practice prepayment plans that might participate in the health maintenance organization option. The other amendments proposed herein are important although a number of them could be classified as technical amendments.

1. Sec. 239(c), page 141, line 18, should be amended to read:

"(c) Notwithstanding the provisions of section 1833 of the Social Security Act, any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of such Act shall, for the duration of such agreement, be entitled to reimbursement only as provided in section 1876 of such Act; *provided, however, that a plan now being reimbursed under part B of Medicare on a per capita basis as a group practice prepayment plan and other plans that qualify for such treatment may continue to be reimbursed on that basis for beneficiaries who are enrolled in part B and are not entitled to benefits under part A or beneficiaries that are entitled to benefits under both part A and B, who are members of the plan but do not enroll in the health maintenance option.*"

To avoid disruptions in the operations of group practice prepayment plans it is important that those that qualify be permitted to continue receiving payments for part B beneficiaries on a per capita basis even though the beneficiary does not qualify for participation under the health maintenance organization option either because he is not entitled to part A benefits or because he does not elect the health maintenance organization option for various reasons such as inability to make an election, refusal to make an election, or a considered judgment that an election would be to his disadvantage. It is essential that some provision be made for payment to group practice prepayment plans on a non-fee-for-service basis in such situations. (See Exhibit B)

2. Sec. 1876(a)(2), page 137, line 17. This line should be amended to read: "be furnished *in the same general geographical area* by other than health maintenance organizations".

Health care costs vary in different geographical areas so significantly that it is essential that the concept of geographic comparability be expressed in the statute. This is particularly important to a number of group practice prepayment plans which operate in metropolitan areas where the cost of health care is the highest.

3. Sec. 1876(g)(1), page 141, lines 2 and 3 should be amended to read: "shall not exceed the actuarial value *in the same general geographical area* of the cost-sharing provisions applicable under part A and part B."

Here again, geographical differences in the cost of medical care should be recognized.

4. Add Sec. 1876(h) commencing on page 141, line 13, to read:

"*(h) The Secretary shall periodically evaluate the performance of health maintenance organizations as compared to other sources of health care services and shall separately evaluate group practice prepayment plans, individual practice prepayment plans and other categories of health maintenance organizations. Each such category shall be defined by the Secretary in regulations.*"

At this time there are two established types of organizations that fall within the definition of health maintenance organizations; group practice prepayment plans and individual practice prepayment plans, such as the Foundation for Medical Care of San Joaquin County. It is contemplated that other types of plans will also qualify as health maintenance organizations. Since there are fundamental differences between group practice prepayment plans and individual practice prepayment plans, and there undoubtedly will be fundamental differences between such plans and other types of plans that qualify as health maintenance organizations, it is essential that the evaluation of the performance of health maintenance organizations be related to the distinct categories of plans.

5. Sec. 1876(a)(2), page 137, lines 8–11. Insert the words "or resources" immediately following the word "utilization" in line 9 so that the language within the parentheses reads "(with appropriate actuarial adjustments to reflect the difference in utilization *of resources* between its members who are under age 65 and its members who are age 65 and over)."

Associations of providers are in the process of developing new measures of utilization of resources in the health care field. As such measures are recognized as being fair and objective, this language will permit them to be taken into account in determining payments to health maintenance organizations.

6. Sec. 1876(a)(2), page 137, lines 14 and 15. Strike the words "to assure" in line 15 and replace them with the word "for" so that the language within the parentheses reads "(with appropriate adjustments for actuarial equivalence)".

"Assure" is a word which overemphasizes exactness in a situation that requires an approximation in order to make the concept of appropriate actuarial adjustments workable in a practical sense.

7. Sec. 1876(b)(2). Page 138, line 10 should be amended by inserting the words "or arranges" immediately after the word "provides".

This is a technical amendment which conforms this subsection to the intent of Section 1876(b)(1).

8. Sec. 1876(b)(3), page 138, line 19. The word "primarily" should be inserted following the word "services." The provision would then read ". . . organization or under an arrangement with an organized group or groups of physicians which is or are reimbursed for services *primarily* on the basis of an aggregate fixed sum or on a per capita basis;"

The bill should permit reimbursement to a group of physicians to include elements such as payments toward retirement plans and incentive payments, in addition to reimbursement primarily through fixed sum or per capita payments. For example, retirement and incentive payments are significant aspects of the Kaiser Foundation Medical Care Program although per capita payments are the primary source of reimbursement to the contracting medical groups.

9. Sec. 1876(b)(6), page 139, line 3. This section should be amended to read:

"(6) has arrangements for assuring that the health services required by its members are received *appropriately* and that the services that are received measures up to quality standards in the community; and"

Retention of the word "promptly" would lead to many administrative problems since "promptly" means something different to every individual. The important test is that services be received appropriately. Treatment for a severed artery must be immediate. A routine physical exam can appropriately be scheduled for next month.

10. Also, this section as written would require the Secretary to regulate quality standards for health maintenance organizations. It is doubtful that the Secretary should undertake to regulate the quality of health care. The section would also require the health maintenance organization to establish quality standards in accord with the Secretary's regulations. Since many of the health maintenance organizations would be managed by lay persons, it would probably be neither desirable nor meaningful for them to establish quality standards.

PLANNING PROVISIONS

The following suggestions are made with regard to the provisions of H.R. 17550 that relate to institutional and facility planning.

1. Sec. 231(f), page 122, line 23. This subsection would amend section 1861 by adding a new subsection (z) relating to institutional planning. The first sentence of subsection (z) should be amended to read:

"(z) An overall plan and budget of a hospital, extended care facility, or home health agency (*or a group of such providers under common management*) shall be considered sufficient if it—"

This provision would permit organizations which manage a number of providers in the same geographical area to present an overall plan and budget for their entire group of providers.

Subsection (z) should also be amended by adding subparagraph (5) commencing on page 123, line 24, to read:

"(5) *Annual operating budgets and capital expenditure plans that substantially meet the intent of this subsection will be accepted. It is not the intent of this section to impose requirements for preparation of operating budgets or capital expenditure plans which are inconsistent with the operating principles of the provider.*"

Subsection (z) could be used as a means of forcing all providers to use standard forms for annual operating budgets and capital expenditure plans which would not recognize the distinctions between types of providers and the special needs of their management. For example, providers that operate primarily as a part of an organized group practice prepayment program have substantially different requirements from fee-for-service providers.

2. Sec. 1122 places limitations on federal participation for capital expenditures under titles V, XVIII and XIX. Sec. 1122(d)(2), page 85, line 20, provides that the Secretary could determine not to exclude expenses relating to capital expenditures of a health care facility when such exclusion would not be consistent with the effective organization and delivery of health services.

We believe this is an important provision which should be retained. This authority should be of substantial assistance in assuring fair evaluation of capital expenditures by planning agenices and in making sure that actions with regard to capital expenditures will not substantially interfere with efforts to organize and deliver health services more effectively. This subsection recognizes the possible conflict between the provisions to encourage health maintenance organizations and limitations by planning agencies on capital investments.

Senator BENNETT. May I have a question?
Senator ANDERSON. Senator Bennett.
Senator BENNETT. Because of the nature of your practice and your programs and assuming you are familiar with the professional standards review amendment, would any of you like to comment on it.
Dr. SAWARD. Yes. The amendment had given rise to some concern that has already been discussed here this morning, in giving priority, as it said, to the local county medical society. But if, as previously interpreted this morning, there are alternative methods of equal priority in peer review, the method becomes considerably more feasible in carrying out peer review through a variety of organizations.
Senator BENNETT. Leaving out the question of the county medical societies, do you feel that the physician or a combination of physicians is the best type or the best source of getting satisfactory review or can you suggest another source?
Dr. SAWARD. The prepaid group practice plans have for years had quite, before medicare existed, adequate peer review of their operations—internal to be sure, but from time to time external as well audit. Professionally it is felt that peer review is a very sucessful means of accomplishing the goals of the amendment.
Senator BENNETT. If the Bennett amendment were put into the law would physicians operating under your system be willing to join with others outside the system to form groups?
Dr. SAWARD. Absolutely.
Senator BENNETT. So that, in effect, you fear that we are going to require setting up peer review organizations, completely outside your organization, if that is eliminated, does that eliminate some of your concern?
Dr. SAWARD. The concern is—and it is based on some history—that the understanding of prepaid group practice is often not complete upon the part of all physicians. Nor, as previously discussed here by Professor Chase, in universities, is it felt that the activities of the university and its health care services are fully understood by physicians necessarily locally. Therefore, a complete representation of such elements doesn't create a peer group. A peer group must truly be a peer group and not a narrowly based group.
Senator BENNETT. Well, doesn't the so-called Bennett amendment give an opportunity to create the kind of understanidng that might greatly improve the situation?
Dr. SAWARD. Yes. The language, as you qualified it earlier, clarifies the matter of priority that it is not quite the way a preliminary reading indicates.
Senator BENNETT. Just a matter to satisfy my own curiosity, do doctors who practice in your organization, keep out of the county medical associations or do they affiliate with them?
Dr. SAWARD. The overwhelming majority of members of the medical groups with which I have been associated have been members of their county medical society, and I have been a member of organized medicine for over 30 years.
Senator BENNETT. So the line is not mutually exclusive.
Dr. SAWARD. No.
Mr. BRINDLE. I think there is a point that in HIP, the last president of the New York Medical Society was an HIP physician.

Senator BENNETT. And I wonder if the fear or the idea that there might be two antagonists or two groups that did not understand each other probably can be discounted, particularly if it is understood that in seeking a true peer review organization the Secretary should see the value of using doctors practicing in teaching hospitals, doctors practicing in HMO groups.

Mr. BRINDLE. I think despite progress there is still a considerable lack of understanding, as Dr. Saward put it kindly, about the development of group practice plans and their extension, so that I think you would have to be alert to see that the peer review group which would possibly dominate would be used sympathetically, and I notice in your statement that you take account and are alert as to it.

I am also under the belief that as Dr. Saward indicated, the experience of peer groups in existing prepaid group practice plans could well be utilized and are quite effective.

Senator BENNETT. Also the bill does not lock in the first peer review group that may be selected in a given community. If it is discovered that there is prejudice or malice or an improper attitude toward review, the Secretary is empowered, indeed he is more or less mandated, to replace that particular group with another one that is more effective.

Dr. SAWARD. The only viewpoint we represent is that one should be alert to the safeguards and I think the testimony now has indicated that.

Senator BENNETT. Thank you very much. I have no other questions, Mr. Chairman.

Senator ANDERSON. Thank you for your testimony.

Mr. Vohs.

STATEMENT OF JAMES VOHS, EXECUTIVE VICE PRESIDENT, KAISER FOUNDATION HEALTH PLAN, INC.; ACCOMPANIED BY DR. CECIL C. CUTTING, EXECUTIVE DIRECTOR, THE PERMANENTE MEDICAL GROUP; AND MICHAEL PARKER, LEGAL ADVISER, KAISER FOUNDATION HEALTH PLAN

Mr. VOHS. Mr. Chairman and members of the committee, I am James Vohs, executive vice president of the Kaiser Foundation Health Plan. With me today are Cecil Cutting, executive director of the Permanente Medical Group, the partnership of physicians which provides the professional services to Kaiser Foundation Health Plan members in northern California. Also with me is Michael Parker, legal adviser to the Kaiser Foundation Health Plan.

The Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, in close cooperation with six separate and independent medical groups, make up the largest group practice prepayment program in the United States. In recognition of the close and vital relationship of the Permanente Medical Groups, to the Health Plan and Hospital Corp., we describe our mutual effort as the Kaiser-Permanente Medical Care program.

This program provides most of the medical and hospital services to over 2,100,000 persons through 21 hospital-based medical centers and 54 outpatient facilities.

I'll try to keep my remarks brief, and respond only to the provisions in H.R. 17550 that have to do with the Health Maintenance Organization.

First of all, there is a fundamental difference between group practice payment programs, such as our own and traditional health care arrangements. In essence, the distinction is that we assume responsibility for both organizing and arranging for the delivery of health care services.

We believe it is essential that the Federal Government, through its various health programs, utilize every opportunity to encourage the development of new and more effective ways of delivering health care services, especially through health care systems that emphasize preventive services, early diagnosis and treatment. Such programs shift motivation away from the provision of high-cost services toward the provision of medically appropriate care, which is generally less expensive. The HMO proposal contained in H.R. 17550 represents a desirable approach toward stimulating the development of the kind of organizations which not only take responsibility for providing services but also include incentives to control costs as well.

We support completely the statement that has been submitted to this committee on behalf of the Group Health Association of America.

Specifically, we urge that the provisions of H.R. 17550 relating to health maintenance organizations be amended so that group practice prepayment plans can continue to be reimbursed on a per capita basis for members who are entitled to part B medicare benefits but who do not qualify for the HMO option, or do not elect the option.

More importantly, we urge your serious consideration to the provision of effective incentives for medicare beneficiaries to elect HMO option and for prospective HMO sponsors to develop health maintenance organizations.

It is especially important in order to accelerate the development of HMO's that the Government be willing not only to support systems of health care, but also to commit significant capital to help create new health care resources.

We cite the report of the Secretary's Task Force on Medicaid and Related Programs, and specifically the provisions in that report concerning 5 percent "front-end money" as such an incentive.

Group practice prepayment programs have consistently held that a single per capita method of payment is fundamental to their effective operations. We continue to request, as we have before, that the Congress eliminate any doubt that combined part A, part B per capita payment under medicare is authorized for qualified group practice prepayment plans. An amendment to accomplish this is attached to our prepared statement.

We appreciate very much the opportunity to present our views to this committee, and we stand prepared to answer any questions you might have.

(The prepared statement of Mr. Vohs follows. Hearing continues on p. 488.)

Statement of Kaiser Foundation Health Plan, Inc.

Summary

Mr. James Vohs and Dr. C. C. Cutting presented the following statement on behalf of Kaiser Foundation Health Plan, Inc., the largest comprehensive prepaid group practice health care program in the United States:

(1) As a member organization of the Group Health Association of America, we support and associate ourselves with the GHAA statement.

(2) We believe that the HMO proposals represent a desirable approach toward encouraging effective health care delivery systems. Amendments presented in detail by GHAA are essential to realize the constructive intent of those proposals.

(3) To stimulate development of non-profit HMO's, commitment of resources by the government far beyond that suggested by the HMO proposals will be required.

(4) A single per capita method of payment (not related to costs or charges for individual units of service) is fundamental to the effective operation of group practice prepayment plans. We continue to urge, as we have before, that the Congress eliminate any doubt that combined part A-part B per capita payment under Medicare is authorized for qualified group practice prepayment plans. An amendment to accomplish this is attached to our statement. The amendment is entirely compatible with the HMO proposal, and both should be adopted.

Statement

Mr. Chairman and Members of the Committee:

I am James Vohs, Executive Vice President of Kaiser Foundation Health Plan, Inc. I am responsible for operations of the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals in Southern California and Colorado. With me are Cecil C. Cutting, M.D., Executive Director of The Permanente Medical Group, the partnership of physicians that provides professional services to Kaiser Foundation Health Plan members in Northern California, and Michael Parker, a legal advisor to Kaiser Foundation Health Plan.

The Kaiser-Permanente Medical Care Program

Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, in close cooperation with 6 separate and independent Permanente Medical Groups, conduct the largest comprehensive prepaid group-practice health care program in the United States. In recognition of the close and vital relationship between the 6 Permanente Medical Groups in the Hospital and Health Plan corporations we describe our total mutual effort as the Kaiser-Permanente Medical Care Program.

This program provides most of the hospital and medical care services for about 2,100,000 persons through 21 hospital-based health centers and 54 outpatient medical office facilities. These facilities are located in the metropolitan areas of Northern and Southern California, the Greater Portland Metropolitan Area in Oregon and Southern Washington, the Greater Cleveland Area in Ohio, Denver, Colorado, and on the Islands of Oahu and Maui in Hawaii. The 6 Permanente Medical Groups—one operating in each geographical area served by the Program—assume essentially complete responsibility for providing professional services to persons enrolled in the Health Plan. Hospital services to Health Plan members are provided primarily through 21 self-supporting and nonsubsidized Kaiser Foundation Hospitals.

Our program is fundamentally different from traditional health care arrangements. We organize direct medical and hospital services to meet the health care needs of a defined population comprised of our Health Plan members. This organized system and the utilization and cost data derived from it constitute a yardstick by which other health care delivery methods can be measured. It has been operating for more than 25 years. Consumer acceptance of the program in the areas where it operates has been impressive. Membership growth is limited primarily by our ability to finance facilities and to staff them with professional and management personnel.

The National Advisory Commission on Health Manpower reported that "the average Kaiser member obtains high quality medical care for 20–30 percent less than the cost of comparable care obtained outside the Plan. The study group also concluded that the majority of savings achieved by Kaiser result primarily from

effective control over the nature of medical care that is provided and the place where care is given."

A number of independent studies support the relative efficiency of the Kaiser-Permanente Medical Care Program For example, these studies show that Health Plan members use roughly 30 percent fewer hospital inpatient days than persons who receive their care under other arrangements. Some of these studies are cited in Exhibit "A", attached.

Support of statement presented by Group Health Association of America

We wish to express our support for the statement submitted to this Committee on behalf of the Group Health Association of America. We believe it is essential that the provisions of H.R. 17550 relating to health maintenance organizations be amended so that group practice prepayment plans can continue to be reimbursed on a per capita basis for members who are entitled to Part B Medicare benefits, but do not qualify for the HMO option or do not elect such option. The technical amendments suggested by GHAA are also important. We ask you to note particularly the suggestion that different categories of health maintenance organizations should be separately evaluated. Most important, we urge your serious consideration to provision of effective incentives for Medicare beneficiaries to elect the HMO option and for prospective HMO sponsors to develop health maintenance organizations.

A perspective on the "Health Care Crisis"

The rapid escalation of health care costs, combined with problems of accessibility of services, adequacy of health manpower and issues of quality, combine to produce what has often been described as a "health care crisis." Many components of this problem have received extensive consideration within the Federal Government and before this Committee, and we do do not wish to take your time to belabor the obvious.

Primary among health care issues is the problem of promoting more effective organization of the health care industry to the end that the resources now available and in prospect to meet the health care needs of our society may be more effectively utilized.

The prosposal before this Committee to encourage "health maintenance organizations" represents a significant and constructive departure from traditional governmental approaches and one which, in broad concept, we heartily endorse. The type of potential health maintenance organization with which we are involved and which we understand—the nonprofit group practice prepayment plan—constitutes an approach to the organization of health care resources to meet public needs which has demonstrated its effectiveness over an extended period of time. This we believe is adequately evidenced by the references cited in Exhibit A. Other possible types of health maintenance organizations, such as medical society foundation plans and various possible health care systems organized to produce a profit for private investors, do not fall within the scope of our experience and knowledge. Thus our comments on the HMO proposal are directed solely to the application of this concept to group-practice prepayment plans operating on a nonprofit basis.

Despite the record of achievement established by group practice prepayment plans and the considerable growth of individual programs, this approach to the delivery of health care services has not developed in the manner one expects of an effective response to an important problem. We believe that the reasons for such limited development are not difficult to find.

Even in the absence of occasional legal restrictions and common resistance to significant change from traditional ways, the establishment of a successful group-practice prepayment program requires a combination of ingredients not readily assembled—(1) dedicated professional leadership sufficient to organize and manage an effective group of physicians (all of whom have excellent opportunities in traditional practice) into a form of practice which departs significantly from established concepts in the profession; (2) capital sufficient to acquire or establish hospital and medical office facilities organized to function in a unitary fashion, and to meet starting-up costs and probable operating deficits while the program becomes soundly established; and (3) management, in addition to the professional leadership, sufficiently skilled to produce, in close cooperation with the professional leadership, an effective total organization.

Although none of these ingredients is readily available, the problem of starting-up capital is particularly difficult, especially in the case of nonprofit programs. To put this problem in perspective, we suggest for comparison the federal

effort and investment under the Hill-Burton and Hill-Harris Programs. This now represents a cumulative expenditure exceeding 3½ billion dollars. While such investment has stimulated considerable expansion and improvement in our Nation's nonprofit hospital system, it has had little constructive impact on the much more difficult problem of stimulating the organization and growth of more effective health care delivery systems. We suggest that from a broad health policy viewpoint there is an urgent need for efficient health care delivery systems—a need at least as great in 1970 as was the need for expanding and improving hospital facilities immediately following World War II. We believe the magnitude of the resource commitment required to bring this about will be at least equally great.

Understandably the Committee with appropriate concern for problems of the federal budget may be skeptical of suggestions involving federal financial commitments. However, the government is expending billions of dollars every year for health care services. These billions are being poured into the dominant traditional pattern—fee-for-service payment for medical care and cost or cost-plus reimbursement for hospital care. Unavoidably these billions support, strengthen and further solidify existing arrangements for delivering health care services despite the evident inadequacies of these arrangements. By comparison the resources directed toward producing constructive change are minimal, and we suggest to this Committee that the constructive change which is so vitally needed will be brought about only through major commitment.

In the nonprofit sector a program to stimulate the growth and development of health maintenance organizations cannot possibly succeed without adequate sources of initial financing. The Report of the Task Force on Medicaid and Related Programs, cited in Exhibit A, makes some useful suggestion in this connection, especially at pages 26 through 38.

Our experience under medicare

In 1965, we expressed concern regarding the impact which the original Medicare legislation—fundamentally oriented toward the insurance concept of cash payment—would have on organizations such as ours which provide health care services directly instead of acting as payers of hospital and medical care bills. Our experience under Medicare confirms the conerns which we expressed to this Committee. Howevor, through extensive work with able and conscientious personnel in the Social Security Administration many, but not all, of the problems have been resolved. More than 70,000 of our members are Medicare beneficiaries who receive most of their health care from our Program under a combined Medicare-Kaiser Foundation Health Plan coverage which fills most of the gaps in Medicare and includes preventive health care services. Under an arrangement worked out with the Social Security Administration, we are paid on a per capita basis for services provided under part B of Medicare. However, Kaiser Foundation Hospitals is paid for part A services for Health Plan Members on a cost-for-each-service basis—an arrangement which does not harmonize with our normal method of operation, and which tends to undermine the constructive incentives which are inherent in a hospital-based group practice prepayment program.

Comprehensive per capita medicare reimbursement for qualified group practice prepayment plans

Group practice prepayment plans have consistently urged that Medicare and other governmental programs should permit a per capita or similar method of reimbursement which does not relate compensation directly to costs of or charges for individual services such as "cost per patient day" or other variations on the fee-for-service system of payment. This point received recognition in the original Medicare legislation which does authorize "per capita" payment for part A services. Unfortunately, other provisions of the Medicare Act as interpreted and administered have thus far operated to preclude a per capita or similar contractual method of payment under part A.

Group practice prepayment plans should be encouraged to operate with the same degree of efficiency for members who are Medicare beneficiaries as for the rest of their members. Unfortunately, the present method of cost reimbursement under part A of Title XVIII militates against this result. In fact, the present method of reimbursement tends to erode the very incentives which have produced substantial economies.

In July 1969, the Health Insurance Benefits Advisory Council in its Annual Report on Medicare (covering the period July 1, 1966 through December 31, 1967) made the following recommendation for legislative action:

"The Council recommends that legislation be enacted authorizing the Secretary to negotiate capitation reimbursement payments to group practice prepayment plans."

We urge this Committee to make clear, by adopting the Amendment attached as Exhibit B, or in some other effective manner, that a per capita or similar method of payment consistent with the operating principles of group practice prepayment plans constitute an authorized method of payment for both part A and part B services under Title XVIII of the Social Security Act. Such method of payment should be available to plans which the Secretary finds to be qualified and should not be limited to experiments. We believe that the adoption of this Amendment would be thoroughly compatible with the adoption of the HMO provisions, and we urge the Committee include both provisions in the reported bill.

Thank you for the opportunity to appear and present our views to this Committee.

EXHIBIT "A"

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EXHIBIT "B"

SUGGESTED AMENDMENT TO TITLE X–III TO PERMIT COMBINED PART A–PART B PER CAPITA PAYMENT

Add paragraph (5) to Section 1861(v) defining "reasonable cost":

For the purposes of establishing reasonable costs of services on a per capita basis as authorized in paragraph (1), and of establishing reasonable costs of service under Section 1833(a) in determining payments to an organization which provides medical and other health care services (or arranges for their availability) on a prepayment basis with respect to individuals enrolled in such

organization, reasonable costs may be established and prepaid on a combined per capita basis encompassing benefits provided by such organization which fall within the scope of part A or part B of this title, or both. In determining rates of payment to such organizations pursuant to this paragraph the Secretary shall apply the principles utilized by such prepayment organizations since June 30, 1966 in reasonably allocating costs of services provided by such organizations between beneficiaries of part A and part B of this title and other persons enrolled with such organizations. All financial requirements of such organizations applied in determining prepayment rates for enrollees not covered by this title shall be deemed to constitute reasonable costs.

In order to permit such organizations, which assume responsibility for providing or arranging for a substantial portion of the health care services covered by this title on behalf of beneficiaries enrolled with such organizations, to maintain their incentives for effective organization of health care services and effective utilization of health care resources, the Secretary shall interpret and apply the foregoing provisions liberally unless the Secretary shall reasonably determine, on the basis of substantial evidence, that the total payment by the Insurance programs established by this title on account of covered services provided by any such organization to beneficiaries of this title enrolled therein would probably exceed the total amounts payable for a generally comparable population of individuals residing in the same general geographical area who are not enrolled in an organization to which this paragraph is applicable.

Allocation of payments, pursuant to this paragraph between the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall be made on the basis of reasonable estimates.

Senator ANDERSON. Any questions?

Senator WILLIAMS. No questions.

Senator BENNETT. No questions.

Senator ANDERSON. You have made a good presentation. We appreciate and express our thanks to you for your being here. Thank you very much.

Dr. Harrington.

STATEMENT OF DR. DONALD C. HARRINGTON, MEDICAL DIRECTOR, SAN JOAQUIN FOUNDATION FOR MEDICAL CARE

Dr. HARRINGTON. I am Donald C. Harrington, M.D. I am a practicing obstetrician in gynecology and diplomate of the American Board of Obstetrics and Gynecology, and the director of San Joaquin Foundation for Medical Care.

My prepared remarks go in to some depth as to HMOs. I would like to merely state here that HMOs, if properly conceived, properly supervised, are, in my opinion, a method of enchancing medical care in this country. Unproperly supervised they could be chaotic.

Also, I feel that HMOs will be a long time coming because of the organizational difficulties involved and, therefore, I would like to spend a few moments that I have in making verbal remarks to discussing Senator Bennett's amendment.

There are certain points: Let us start out by saying that I obviously am in favor of Senator Bennett's amendment, and I hope that the committee recalls that approproximately 5 to 6 weeks ago I appeared before you and presented certain information regarding the kinds of patient profiles provided, profiles that are notices to carry on review, and I pointed out to the committee when I appeared before you previously the need for this kind of ongoing medical care review.

I will not dwell on this kind of thing at this session, but I would like to go on to a more detailed discussion of what I consider peer review, what it ought to be, and how it is best handled.

Peer review is in its best terms review by its peers. I, as an obstetrician and gynecolgist, cannot properly review the work done by an orthopedic surgeon. I, therefore, cannot properly review the kinds of work done by pharmacists. But I want to also here draw the attention of the committee that, though we in medicine only receive payment for a small percentage, some 12 to 15 percent of the funds, we are ordering approximately 80 percent of all of the funds that are spent under the various medical care programs.

When we get down to peer review of pharmacy, we must separate between the errors of commission of physicians, such as the overprescribing of amphetamines to teenage kids, the overprescribing of antibiotics indiscriminately. There are physician peer review problems.

Pharmacists also have their peer review problems, the splitting of prescriptions for a financial gain, the refilling without contacting the physician on refills, these are things that occur in a pharmacy area and these should be subject to pharmacy peer review. The pharmacists should be subject to pharmacy peer review. The pharmacists should be involved in the peer review system to correct those errors that are truly pharmaceutical.

The same thing is true in the hospital. The hospital has problems which are mainly physician developed. Overutilization of stays, unnecessary entry into the hospital, the overuse of surgery, the overuse of electrocardiography, laboratory work, and so forth, these are things that necessitate peer review by physicians, and the hospitals have gone a long way with their utilization committees, surgical committees, medical audit committees to carry on this kind of physician peer review.

I am very interested in seeing the uprising of the American Hospital Association against the Bennett amendment, and I think the uprising is mostly due to the fact that the good hospitals are uprising. I am sure the letters you are receiving if you would study them, come only from hospitals that are already involved in PSRO. They are already involved in adequate review, but they have not sat in a chair that I sat in and reviewed the community as a whole and realize that a physician is not allowed to do a hysterectomy in one hospital, goes across the town to do it in another hospital.

Therefore, the Bennett amendment allows us to give a total community perspective, which is what the hospitals in California have been doing for some 14 years, and it is on this basis that I feel so strongly involved with the Bennett amendment.

Back to peer review: The hospitals should not fear peer review because those things that have to do with hospital abuses, such as the requirement of an X-ray of a chest in every admission in a proprietary hospital where the X-ray person owns part of the hospital; the requirement of an overabundant laboratory in a proprietary hospital where the laboratory is owned by one of the hospital owners. These kinds of things will have to be subjected to hospital peer review.

The good administrators which are by far the largest in our country will be able to see the things that are going on in all hospitals, not just in the local hospitals.

Now, peer review has to do with the discipline of the individual, be he a podiatrist to review podiatry, an optometrist to review optom-

etry, but also the geographic location. Geographic location is important.

We in San Joaquin County cannot review the work of physicians in Alturas. There are differences and distances from the hospital requiring longer hospitalization and earlier hospitalization. We are not capable, even though our generals may be treating the same diseases, to review. Thus we have to bring it to the local level.

This, then, gets down to the area that Dr. Chase Stanford was talking about. Obviously they are not going to require preadmissions for Stanford. Any peer review group that would do this would be in error. However, Stanford would be picked upon on retrospective review.

The statistics that can be developed from all of the flow statistics would say to Stanford, "Now you are—you have a large expenditure in laboratory procedures. How many of these are therapeutic, how many of these are research, and how many of these are teaching."

These kinds of things will be able to be developed, and this kind of thing then can be brought to the attention of the good hospitals that may be overutilizing from the concept of therapy and then decisions should be made, are these payable or not, which is what we are really getting down to. It is good to do them, but who pays.

So I think peer review does have to get down to the local level and the local problems.

Now, I feel strongly that the bill does have one serious error. They are not utilizing the State medical society as well as they could. Now, in Utah, as you mentioned, in Colorado as I am mentioning, certainly the State will probably be the only one, but I think that the Federal Government, when they approach this program in California, would be well-advised to first contact the California Medical Association because they are alert to this problem and they can in turn put pressure on the county medical societies which will bring a more rapidly expanding peer review program than if you leave the State societies out of it entirely.

I have just a few more things if I have the time.

It is very well and good to set up a committee and say, "You now are a peer review committee." This is great. This has been done. The problem is, who decides what gets to that committee, who decides what kinds of material should that committee seek. As far as I am concerned, the provider in the peer group is the only one that can make this kind of a decision, and he must then impact the fiscal intermediary, whoever it may be, and say to that fiscal intermediary "I need to see all the claims for injections of estrogen. I need to see all the claims for injections of estrogen. I need to see all the claims for the injections of vitamin B-12."

These kinds of things have to come up from the peer review to the third party, and then either manual or in the near future computer programing to extract these claims, which will then be sent to peer review.

Now, we have been talking about ongoing review. We were talking about it, I believe, and I think Senator Bennett pointed this out, we are not talking about it in regard to treatment. We are talking about it in regard to payment. We will study the case, decide is payment eligible under the contract of the program or under the type of medical care involved. If so, it will be paid. If not, it will not be paid.

But this does not mean that the service will not be rendered.

Now, this then produces what is so commonly called cost effectiveness, which I take a dim view of. I prefer the words "quality effectiveness" because as soon as we find we are not paying for certain claims of certain physicians, certain pharamacists, certain hospitals, we then label them black cat hospitals, and black cat pharmacists, and physicains, and we give it much more careful scrutiny.

However, we do need peer review to study and find out what the community patterns are.

I would like to say one thing more. Retrospective review is still important, and retrospective review, and I would like to point out, for instance, how one would study the hospitals.

We at the present time are working in California developing an ongoing program of review through the computer. Part of our charge has been from the State of California to develop some retrospective things and we met with the California Hospital Association only 3 days ago and gave them this charge and they are going to study it and see. Some of the things we are studying are, for instance, the number of hospital days per hundred recipients; the number, the charges by hospital departments per hundred recipients; the charges by hospital departments for 100 days. There are specific reasons for each kind of retrospective review, and one of the main reasons is to pick up poor prospective review.

So that retrospective must go along with prospective analysis.

Physician acceptance, I would like to says this: I have had the privilege of speaking before many of the State medical societies in their house of delegates, including New Mexico, and the list of people of hospitals that are at the present time interested in peer review and whom we have personally contacted in California, the State of Nevada, New Mexico, Colorado, both metro Denver and the States of Minnesota, Georgia, New York, two counties or one; just a week ago Wyoming voted to put in a peer review system, and we are speaking in the near future with seven or eight other societies that are interested in this peer review.

So I am sure that the Bennett amendment is meeting—is at a time, it is at a time when medicine is willing to accept this. When I say medicine, I think that the medical profession, the physicians, will have to take the lead in this because of the fact that we order 80 percent of all of the services rendered, but we must then bring in the hospitals, podiatrists, and so forth.

I would like to say one quick word in closing about HMO's. I would not hope in the wording of the HMO's it states that only those organizations who have shown experience in the past will be allowed to become an HMO. I cannot think of any better way of freezing our type of care into the sterile kind of care we have had in the past by freezing it to those people who have been doing it.

I think that it should be allowable for an organization such as New Mexico, who starts out without experience, but who has the ability to call in the necessary administrative expertise to become an HMO. I think this, on the one hand.

On the other hand, the regulations should not be so loose that we will deveop a country cousin chicken HMO that runs from State to State.

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I feel one last thing, and then I will close, and that is that it is impossible for HMO's to start unless you allow some administrative flexibility at the beginning. This business of making them have 50 percent or more people under 65 is going to defeat your purpose.

Secondly, I think that they should be able to reinsure some of their risks with the insurance carriers that know insurance, but reinsure it by the HMO. This is what we do, for instance, with our Federal employees, the hospital is reinsured, we take care of the Federal employee's professional bills. The rest is in my printed statement and I think I need say no more.

Are there any questions?

(Prepared statement of Dr. Harrington follows. Hearing continues on p. 495.)

STATEMENT BY DONALD C. HARRINGTON, M.D., MEDICAL DIRECTOR, SAN JOAQUIN FOUNDATION FOR MEDICAL CARE

I am Donald C. Harrington, M.D., a practicing obstetrician-gynecologist, a diplomate of the American Board of Obstetrics and Gynecology, Fellow of the American College of Surgeons, Fellow of the American College of Obstetrics and Gynecology, and Medical Director of the San Joaquin Society's Foundation for Medical Care.

My purpose in coming before you is two-fold. First, to present some concerns about the development of Health Maintenance Organizations and secondly, to discuss Senator Bennett's amendment on peer review.

The Health Maintenance Organization concept, properly structured and administered, should produce a broader and more equitable distribution of available medical care. These remarks are based on 16 years of involvement with Health Maintenance Organization type plans. The first, 1954, a program developed with the International Longshoreman's and Warehouseman's Union—Pacific Maritime Association Welfare Fund; the second, 1960, the Federal Employees Program; the third, 1962, the State Employees; and lastly, 1966, the Medi-Cal Program.

The discussion on Health Maintenance Organization problems will be covered under five topics, They are:

1. The underlying *intent* in the development of Health Maintenance Organizations.
2. The administrative structure of Health Maintenance Organizations.
3. The relationship of insurors to Health Maintenance Organizations.
4. The requirements for an organization to qualify as a Health Maintenance Organization.
5. Surveillance of operational Health Maintenance Organizations.

The remarks that follow are not intended as a comprehensive discussion of the listed topic but only the presentation of few problem areas for discussion.

1. THE UNDERLYING INTENT IN THE DEVELOPMENT OF HEALTH MAINTENANCE ORGANIZATIONS

Perhaps the most important area of discussion is the intent, first by the Government and then any other involved organizations inasmuch as the intent will in fact structure the program. If the intent is solely for immediate dollar savings, Health Maintenance Organizations are not the answer. If the intent is for "cost effectiveness and quality effectiveness", Health Maintenance Organizations are certainly worthy of study. It is obvious to all concerned that an early diagnostic medical care program will uncover disease and will produce additional early costs. The savings in human misery as well as monetary costs on the longterm basis however are great. The best illustration is the Papanicolaou smear while if universally utilized, would, in the short range, increase the hysterectomy rate considerably, but in the long range, cut down the need for radical surgery, cobalt and other radioactive modalities. With the hope that the intent is for good medical care, we will proceed to number 2.

2. THE ADMINISTRATIVE STRUCTURE OF HEALTH MAINTENANCE ORGANIZATIONS

Because of the broad scope of medical care problems ranging from early diagnostic services through terminal cardiac care in a longterm care facility, involving the multitude of providers working as a team, it is obvious this type of program cannot be set up by totally administrative personnel as is the case in the present insured programs. It is our feeling from past experience, that to be successful, all providers that are rendering care under a Health Maintenance Organization should be teamed as a management group to develop the medical care programs that are suitable for adequate patient care. This required that physicians, hospitals, pharmacists, podiatrists, optometrists and all other providers, group in a team effort to provide a comprehensive program and utilize the funds already being spent in a broader and more equitable manner. Administrative personnel and computer people will be essential to the success of this type program, they would hopefully have had experience in medical care programs prior to relating to the health professionals in producing the Health Maintenance Organization. The first ingredient of a Health Maintenance Organization is *involvement* and requires that the health professionals become involved intimately with the administrative aspects of the program.

3. THE RELATIONSHIP OF INSURORS TO HEALTH MAINTENANCE ORGANIZATIONS

The San Joaquin Foundation for Medical Care, as noted above, has several programs where the physicians are actually on risk for their services. For practical reasons, the Foundation, through acting as prime contractor in each instance, has "reinsured" for hospital care and for out area professional care through several insurance companies: For the ILWU–PMA, Pacific National; the hospital portion of this program is negotiated directly by the ILWU-PMA; for the Federal Employees Program, Continental Casualty Company, and for the State Employees, Pacific National. This reinsurance is done at a cost of 1% risk charge. The remaining money returns to the Foundation for other medical care purposes. This relationship assures the patient of hospitalization any place in the country and yet maintains local interest of the providers in keeping hospital costs down. It is from this experience that I strongly recommend to the Committee that methods for reinsuring portions of the risk be part of the Health Maintenance Organization law.

4. REQUIREMENTS FOR AN ORGANIZATION TO QUALIFY AS A HEALTH MAINTENANCE ORGANIZATION

I am greatly concerned that the words presently in the Act will present any new and initiative people from entering this new field of health care delivery. The Act states that the person qualifying must have had experience in the field and must also cover individuals not under Medicare as part of the on-going program. This makes it impossible for certain Foundations who are not at present in a risk taking program but who have administered medical care programs of large size over many years on a non-risk basis from being included as a candidate to become a Health Maintenance Organization. Actually, if read loosely, a small insurance company could, working with small groups of physicians, develop a Health Maintenance Organization which could then be franchised from community to community throughout the State much like an "Uncle Eddies Fried Chicken" corporation. Both of these situations are, I believe, obviously bad. There is great interest at the present time in many state and county medical societies in peer review, Foundations for Medical Care, and Health Maintenance Organizations. It is my considered opinion that a properly involved medical society through its Foundation for Medical Care, though it may be inexperienced in the health care administrative field, could, because of experience in the practice of medicine, obtain the necessary administrative personnel to carry on either directly or through reinsurance mechanisms, a very effective Health Maintenance Organization.

5. SURVEILLANCE OF OPERATIONAL HEALTH MAINTENANCE ORGANIZATIONS

It is not enough to develop the concept, the administrative requirements, and the funding for a Health Maintenance Organization without also developing the necessary fiscal, medical and demographic reports. These reports are essential to compare differences in function in various Health Maintenance Organizations

and to discover and spread successful techniques and to discard costly and unsuccessful procedures. These reports are also necessary to assure that Health Maintenance Organizations are developed in the spirit and intent that we have previously discussed and not solely as a fiscal intermediary. This surveillance should be undertaken by the Health Maintenance Organization's administrative people in cooperation with the funding agency for whatever program the Health Maintenance Organization is developed.

This discussion of surveillance leads into the second portion of my testimony and that is a discussion of Senator Bennett's amendment. At the present time there is a tremendous interest in "peer review". The majority of this interest stems from the realization that a comprehensive medical care program, uncontrolled, can be costly because of the excesses of a few providers, and also because it is obvious that these excesses can only be discovered by people trained in the same field as the provider under question. Peer review has been going on extensively in the California Foundations for approximately 16 years. In our experience, peer review, to be effective, must be brought to bear prior to the payment of the provider's bills. This is in contrast to what is actually going on in the Medicare and Medi-Cal programs throughout this country.

The American Medical Association has, over the past several years, voiced its approval of the peer review concept and has indeed stimulated legislation in this direction and is also informing the various state and county medical societies of its posture and stimulating interest in the development of more adequate peer review by the constituent societies. The Federal and State Governments involved in medical care programs are vitally interested. The State of California, with Federal help, has become involved in a program for computerizing ongoing review. The United Federation of Foundations is acting as a subcontractor to devleop the provider criteria for this effort.

To be successful peer review must stem from the local community. The peer review committee doing the study must be involved geographically, by training, and by past experience to the provider whose services are being questioned. The peer review group should have a choice in deciding what types of medical procedures should be subjected to review. This information should be transmitted to the necessary administrative people so that claims can be abstracted, either manually or by computer, for referral to the local peer review group. The county medical society or district medical society is the ideal focus for the preliminary review in as much as physician providers either receive payment for or order the services producing 80% of the medical care costs in a comprehensive program. The experience of the California Foundations has been that approximately 85% of all claims pass directly through the screening mechanism and are capable of immediate payment. 15% are subjected to peer review and 2% require more detailed study by a total committee. These numbers are administratively feasible and require only the proper identification to be brought to study. The primary document involved in peer review is the "patient's profile". On this document all services provided to a patient are listed by date of service, by type of service, by dollars billed and paid and other relevant information. As claims are received, they must be screened against this past history, either by capable claims personnel or by a computer. From this past history relevant to the present claim, decisions are made for payment or non payment or for the need for additional information. When claims are subjected to study, they must be tied in with the patient's profile and the related provider's profile

The provider profile is the second document necessary for review. This consists of a detailed history of all the services rendered, the dates of service, the amounts charged and paid and the past reactions of the provider's peers to his services.

From the above brief account of the ingredients necessary in peer review, it can be seen that:

1. Peer view must relate to the local provider authority.
2. It must be backed up by adequate documentation.

The name of the geographic or administrative area to be covered practically by one peer review committee is not essential. In some instances, it would be a county in California, a district of Los Angeles, or the State of Wyoming. In each, the population of recipients and of providers would be approximately the same.

The limitations of the discovery of aberrant claims is the main problem at the present time. For that reason, the total expansion of the peer review concept throughout the country is not feasible until computer programs that are being developed are operational. Those claims that are discovered are small enough in number and relate to small geographic areas so that they are administratively controllable.

Peer review is so essential to a comprehensive medical care program that the American Medical Association has actually proposed that if a county or state medical association does not rise to the challenge, the Secretary of Health, Education and Welfare would be compelled to make a program operational. I am sure that the physicians in most parts of America will respond to this challenge and develop the necessary peer review organizations and work with State and Federal programs to develop methods of uncovering medical abuses. This program may take some time in development inasmuch as considerable administrative as well as medical education must go on.

Senator BENNETT. I would like to make a comment.

At the beginning of your statement you pointed out that you as an obstetrician cannot review the work of a pharmacist and, as I understand the meaning of the Bennett amendment, you would set up a peer review organization but they would have the power and be urged when they detected a problem with the pharmacies to bring in pharmacists to advise them and help them make a recommendation with respect to pharmacists, and the same way with the basic hospital problems.

Dr. HARRINGTON. When I made this comment, sir, I really was not speaking to the committee. I was really speaking to my conferers in the other disciplines to make them realize that medicine does not want to review pharmacies in hospitals. This has to be a cooperative thing that all of the disciplines get involved in.

Senator BENNETT. And that is exactly what we are after.

Now, I was interested also in your comment about the necessity for restrospective review. It seems obvious to me that we need restrospective review to set up our norms, and once we have set up norms we need restrospective review to keep them constantly corrected, because without some basis of norms, the peer review operation cannot be successful.

Dr. HARRINGTON. Correct.

We, for instance, let us say, in our review work, we trust implicitly upon the utilization of tissue committees, medical audit committees of our better hospitals. We retrospectively, however, pick up aberrations and bring it to their attention to sharpen their particular expertise and it makes everybody honest.

Senator BENNETT. Those are all my comments.

Senator ANDERSON. Thank you very much for a very fine statement.

Dr. HARRINGTON. Thank you.

Senator ANDERSON. Max Shain. Go right ahead.

STATEMENT OF MAX SHAIN, ASSOCIATE PROFESSOR OF MEDICAL CARE ORGANIZATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

Mr. SHAIN. Senator Anderson, and members of the committee, my name is Max Shain, and I am engaged as an associate professor of medical care organization at the University of Michigan, School of Public Health, and for some time I have been studying as well as doing teaching and administration in the field of social security, hospital administration, and health insurance.

My testimony today is related entirely to the medical care program.

For a number of months your Medicare-Medicaid Committee, subcommittee and its staff, have been engaged in examining into the

operation of the medicare program. Their investigations have disclosed a number of most serious shortcomings in the regulations issued by the Department of Health, Education, and Welfare in the performance of the health insurance organizations which administer the program as the Government's agents, and in the activities of the providers of health services.

You have expressed alarm about the escalating costs of the medicare program, as well you might after seeing the premium for physicians and related services rise from $3 to $5.30 a month, and after hearing from the social security actuary that the hospital insurance trust fund faces a deficit over the next generation of $216 billion.

Your colleagues in the House of Representatives have taken straightforward action regarding the fees to doctors and others paid under part B of medicare. They have in effect established a temporary freeze on such fees and tied future increases to a kind of cost-of-living index.

With regard to payments to the hospitals and other providers under part A, the House action was much less direct, and the House was obviously not particularly hopeful about the effects of the actions it took because it raised both the tax rate and the tax base to levels necessary to cover the predicted $216 billion deficit in the hospital insurance trust fund.

My purpose today is to urge that you add provisions to the bill which would do in principle for the costs of providers under part A what the House of Representatives has done for the charges under part B, establish a formula for a ceiling.

The limits that are imposed should serve these ends: Encourage the maintenance of a skilled and stable work force in hospital employment by providing financial support for eliminating differentials in wage rates between hospital employees and workers with comparable qualifications in other employment.

They should provide funds for meeting inflation in the cost of goods that hospitals purchase, and they should spur the development of expert hospital management so that hospital services can be improved without inordinate cost increases.

Specifically, I am proposing that reasonable costs under part A be redefined as calendar 1970 cost plus only: For 60 percent of hospital expenses—represented by wages—amounts necessary to achieve parity in the next 5 years between hospital wages and wages for comparable occupations in other industries, and additional funds after that to maintain such parity; and for the remainder of hospital expenses—represented by nonwage items—amounts necessary to keep pace with changes in an appropriate measures like the index of wholesale prices. I have furnished an advance copy of this proposal to the Office of the Actuary of the Social Security Administration. They may be able to furnish this committee with an estimate of the tax increase necessary to finance this proposal. I would expect that the tax increase would be quite a bit lower than that contained in the House bill.

How is my time?

One last point I would wish to make.

I would believe that it would be very necessary for your committee and its staff to maintain an extremely close liaison, close contact, close surveillance, over the regulations as they are developed in the Depart-

ment of Health, Education, and Welfare and administered in the field. Your staff's investigations have, as I have said before, disclosed very serious shortcomings of cases where the clear intent of the law was twisted, subverted, in fact, in the regulations issued and in the actions taken out in the field. This is a situation that you cannot allow to continue, and by the use of your staff and other means that you have at your disposal, it would be most important that you maintain this oversight so that the regulations do not twist the law, as in fact they very often have in the past.

(Prepared statement of Mr. Shain follows:)

STATEMENT OF MAX SHAIN

SUMMARY

The major point of this testimony is a proposal to limit increases in payments to hospitals under the Medicare program. The limitation would be achieved by tying changes in Medicare reimbursement to an index which would be composed of two factors. The first factor would cover amounts necessary to achieve parity in wages for hospital workers with wages for comparable occupations outside of hospitals, and the second would reflect changes in wholesale prices.

STATEMENT

Mr. Chairman and Members of the Committee: My name is Max Shain and I am a resident of Ann Arbor, Michigan, where I am employed as an Associate Professor of Medical Care Organization at the University of Michigan School of Public Health. For some thirty years, I have been engaged in teaching, research, and administration in the social security, hospital, and health insurance fields. My testimony today is related entirely to the Medicare program.

As we look back over the five years since the Medicare program was adopted in 1965, we are inclined to emphasize its difficulties and shortcomings. Perhaps this is inevitable at a time when the opportunity for making improvements is at hand. In this critical atmosphere, let us not overlook that the enactment of Medicare was a major advance in American social policy. Through this law the nation recognized the fundamental right of a major segment of its citizens, the aged, to health services. The Congress guaranteed this right through the social insurance system.

With all the misgivings that have developed since the program was enacted, particularly over the inflation in medical costs that we have seen since 1965, we must not forget that through this law, more health services have been brought to our aged citizens than ever before. We have honored ourselves by establishing the principle of the right to health services, with these services to be made available under conditions of dignity. Special mention must be made of the contribution of Senator Anderson, chairman of your subcommittee on Medicare and Medicaid, as sponsor of the Medicare legislation.

For a number of months, your Medicare-Medicaid subcommittee and its staff have been examining the operation of the Medicare program. Their investigations have disclosed a number of most serious shortcomings in the regulations issued by the Department of Health, Education and Welfare, in the performance of the health insurance organizations which administer the program as the Government's agents, and in the activities of the providers of health services.

You have expressed alarm about the escalating costs of the Medicare program, as well you might after seeing the premium for physicians' and related services rise from $3.00 to $5.30 a month and after hearing from the Social Security actuary that the hospital insurance trust fund faces a deficit over the next generation of 216 billion dollars.

Your colleagues in the House of Representatives have taken straightforward action regarding the fees to doctors and others paid under Part B of Medicare. They have, in effect, established a temporary freeze on such fees and tied future increases to a "cost-of-living" index.

With regard to payments to hospitals and other providers under Part A, the House action was much less direct, giving encouragement to experimentation and planning and authorization to the Administration to control payments to the

institutions whose costs were most outrageously out of line with others. The House was obviously not particularly hopeful about the effects of these steps. It raised both the tax rate and the tax base to the levels necessary to cover the predicted 216 billion dollar deficit in the Hospital Insurance Trust Fund.

My purpose here today is to urge that you add provisions to the bill which would do in principle for the costs of providers under Part A what the House of Representatives has done for the charges under Part B—establish a formula for a ceiling.

The limits that are imposed should serve these ends:

1. Encourage the maintenance of a skilled and stable work force in hospital employment by providing financial support for eliminating differentials in wage rates between hospital employees and workers with comparable qualifications in other employment.
2. Provide funds for meeting inflation in the costs of goods that hospitals purchase.
3. Spur the development of expert hospital management, so that hospital service may be improved wtihout inordinate cost increases.

Specifically, I propose that "reasonable costs" under Part A be defined as calendar year 1970 costs plus *only:*

1. For 60% of hospital expenses (represented by wages), amounts necessary to achieve parity in the next five years between hospital wages and wages for comparable occupations in other industries, and additional funds after that to maintain such parity; and
2. For the remainder of hospital expenses (represented by non-wage items), amounts necessary to keep pace with changes in an appropriate measure like the Index of Wholesale Prices.

I have presented an advanced copy of this proposal to the Office of the Actuary of the Social Security Administration. They may be able to furnish this Committee with an estimate of the tax increase necessary to finance this proposal. I would expect that the tax increase would be quite a bit lower than that contained in the House Bill.

It is clear that the time remaining this year for this Committee and the Senate to do their work on this bill is very limited. It would not seem feasible now for you to do a major overhaul of the Medicare program beyond the actions taken by the House of Representatives. I urge you, however, to take this opportunity to join in the House's concern for the program's costs and to extend the House's cost control action to the area of institutional costs under Part A, which represents by far the major part of the Medicare program's expenses.

I would urge, also, that your Committee and its staff maintain continuous contact with the process of drafting the regulations which convert the broad statements of Congressional intent in the law into operation instructions. We must avoid the sad experience of 1965–66, when somehow the cost controls you had intended in a number of aspects of the law were overlooked, or even subverted, in the administrative regulations.

It appears now that the Administration, hell-bent on getting the program into operation, was willing to compromise away the controls which you thought you had specified. The entire nation has been paying for the accelerated inflation in medical prices which was then set off. We pay not only through higher taxes for Medicare and Medicaid, but in higher premiums for the health insurance purchased by workers and employers. For those who have no health insurance or insurance with limited benefits, the burden is particularly severe, since they come face-to-face with vastly inflated prices at the time they are ill.

In deference to your tight schedule, I will end my statement here. As best I can, I will respond to questions you wish to put to me and be available for additional assistance that you may request.

The CHAIRMAN (presiding). Thank you very much, sir.

The next witness will be Mr. Edgar G. Burkhardt, Veterans of World War I.

STATEMENT OF EDGAR G. BURKHARDT, NATIONAL COMMANDER, VETERANS OF WORLD WAR I, USA

Mr. BURKHARDT. Mr. Chairman and members of the committee, I am Edgar Burkhardt, national commander of the Veterans of World War I.

I wonder how much time do you have.

The CHAIRMAN. We have been allowing each witness 10 minutes to summarize his statement.

Mr. BURKHARDT. I have submitted a statement to your committee members and, as a matter of brevity, of saving your time as well as the other people who are waiting, would you mind if I passed up reading the statement?

The CHAIRMAN. No; not at all, just summarize it. We will print the whole statement.

Mr. BURKHARDT. I would like to add this, that we favor, are very strongly in favor of the 5-percent increase in social security, and we are very strongly in favor of the escalation clause as amended in the House bill, that the increases in social security be automatically made as the cost of living goes up. This has been a practice for years in labor-management negotiations and later on it is still being used in the labor negotiations in wage operations.

The social security people, the Federal social security retirees, are benefited by this escalation clause, and we would like to have that in this new bill.

The reason for that is that it is, to move legislation through Congress is necessarily a slow process. There is a certain time lag and certain studies and everything else that enter into it before you come up with an increase and, in the meantime, our people are really suffering.

We have approximately 900,000 World War I veterans who are meeting the stringent income limitations in order to get pensions, and that income limitation is based slightly above the poverty level, and these people have quite a job to live. They are all retired, and we feel that inasmuch as we have helped build up the economy of our country during the years when we were employed, that we should get serious consideration a little bit faster than we have been getting.

The CHAIRMAN. Thank you very much.

Mr. BURKHARDT. I thank you for the opportunity of appearing before you.

The CHAIRMAN. Thank you, sir. We will print your entire statement.

(Prepared statement of Mr. Burkhardt follows:)

STATEMENT OF NATIONAL COMMANDER EDGAR G. BURKHARDT, VETERANS OF WORLD WAR I, USA, INC.

I am Edgar G. Burkhardt, National Commander, Veterans of World War I, and in behalf of the nearly 300,000 World War One veterans and their dependents, I express appreciation in their behalf for this opportunity of appearing before your committee in support of H.R. 17550 as amended, and appeal for your favorable approval and passage of this bill.

There are nearly 900,000 World War One veterans who receive veterans' pensions, and their economic status is such that they have met the stringent income limitations which are based slightly above the Government's established poverty level. Our average age is close to 75 years of age, and all are unemployable and have no means to combat the ever-increasing cost of living as computed by the Department of Labor.

We understand fully that passage of any legislation is a slow process. This creates a time lag after the necessary legislative study and hearings which results in the hardship created on those of us who are recipients of Social Security Benefits. These people suffer in trying to make ends meet during the period

when the cost of living statistics are computed, and the actual increase in Social Security benefits become a reality. Frankly, our people suffer greatly, and wonder how to be able to exist. We can't afford to live and we can't afford to die.

As an humanitarian act, this bill should be enacted into law without further delay as already passed by the House of Representatives.

For example, the cost of living, according to the Bureau of Labor statistics, shows an increase since July of 1969 of 7.6 points.

The amendment to H.R. 17550 which establishes an automatic increase in Social Security payments as the cost of living index increases, which would not only eliminate the hardship of Social Security recipients, but would likewise reduce the time consuming efforts on the part of Congress.

This is not a new method of making adjustments based on the cost of living index. Ever since 1942, every labor-management union contract had a provision; ever so many points increase in the cost of living, an agreed upon increase in wages was made.

Even in World War Two, costs were frozen to keep the cost of living down. The Treasury Department and the General Accounting Office considered such increases fair, and accepted these additional costs when at the termination of a Government contract on war materials, was renegotiated as to costs and ultimate profits. Every Government contract was subject to renegotiation during the War.

Since this was a fair and accepted method, and is even today used in Labor-Management Union contract negotiations, and is successful, it is only fair that people who are recipients of Social Security Benefits be given the same consideration and treatment.

Federal Civil Service retirees, likewise receive automatic increases based on the Cost of Living Index.

Certainly, since these automatic increases have proven so successful in labor-management contract negotiations, and is an accepted method for Federal Civil Service retirees, these recipients of Social Security monthly payments, people who have, through their efforts, technical skills, manual and mental labors and vision, done so much to increase the economic growth of our economy, should be entitled to this same benefit now.

We, in our National Conventions, have passed resolutions to secure such legislation, and therefore urge you to pass H.R. 17550 as amended at this time. Te House of Representatives recently passed this at the same time they passed the additional 5% increase in Social Security.

Twenty Eight years have passed since this automatic increase based on the cost of living statistic was first inaugurated, and we are confident that in fairness, you should now make this a reality for the Social Security recipients.

The CHAIRMAN. The next witness is Dr. Jonathan Leopold, commissioner of mental health of Montpelier, Vt., accompanied by Dr. Kenneth Gaver, administrator, division of mental health, Salem, Oreg., and Harry Schnibbe, executive director, in behalf of the National Asosciation of State Mental Program Directors.

STATEMENT OF HENRY SCHNIBBE, EXECUTIVE DIRECTOR, IN BEHALF OF NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; ACCOMPANIED BY DR. KENNETH GAVER, ADMINISTRATOR, DIVISION OF MENTAL HEALTH, SALEM, OREG.; AND DR. JONATHAN LEOPOLD, COMMISSIONER OF MENTAL HEALTH, MONTPELIER, VT.

Mr. SCHNIBBE. Mr. Chairman, my name is Harry Schnibbe, executive director of the National Association of State Mental Health Program Directors.

The two principal witnesses here today representing State mental health, mental retardation agencies are Dr. Gaver, who is director of the mental health program for the State of Oregon, immediately to my left, and Dr. Leopold on the far left, who is the commissioner of the department of mental health in the State of Vermont.

The representatives of the States in our association administer the largest public health program in the free world.

The State mental health programs embrace thousands of community outpatient and residential hospital facilities.

Several million patients are treated each year through State public programs for mental illness, mental retardation, alcoholism, and narcotic addiction.

The total State budgets administered by the members of this association amount to over $2 billion per year, about $2.5 billion.

The witnesses here today thus represent a group of State officials who have a substantial knowledge of the likely effect of some of the proposed amendments to the Social Security Act amendments of 1970, as contained in H.R. 17550.

Our witnesses here today will speak from their own experiences in their own States. In Oregon and in Vermont, both of our witnesses are responsible for the administration of a whole range of State treatment and rehabilitation services for the mental ill, mentally retarded, alcoholics, narcotic addicts.

Although they come from States on opposite sides of this country, it should be understood by the committee that they will be expounding principles, concerning this proposed legislation, that are substantially the positions of all 54 States and territories.

Today we intend to cover six general subjects in the bill and we invite questions at any time during the presentations. Our testimony is designed to afford interruption by committee members.

The subjects are:

1. Discrimination against the mentally ill in the Social Security Act.
2. Care of the mentally retarded under provisions of the Social Security Act, as especially in the amendments adopted by the House.
3. The need for proper and effective controls on federally funded mental illness and mental retardation treatment programs.
4. Right and necessity of States to be eligible for Federal benefits if they develop and operate different types of intermediate care facilities for both the mentally ill and the mentally retarded.

The bill prohibits this, by the way.

5. Does the Federal title 19 money effectively supplement rather than supplant, as is sometimes charged, State treatment dollars?
6. And last, responsibility for determination of uniform mental health and mental retardation treatment standards.

Mr. Chairman, we have several specific amendments to the bill. They are listed on a separate sheet of paper, which you now have before you, and which we will be happy to make available to anyone who desires it.

I will run through the amendments to be sure there are no technical questions about where they might be located in H.R. 17550. Then Drs. Gaver and Leopold will discuss with you the reasons why the States seek these amendments that we propose.

There are four specific amendments. Without reading all the details of where the amendments are because they are specified in the statement here, the first amendment refers to—well, let me say this: The title of section 225 on page 103 of this bill is totally misleading. The title says:

"Establishment of Incentives for States To Emphasize Outpatient Care Under Medicaid Programs."

The title should read:

"Establishment of an Accounting Device to Slash the Federal Medical Care Budget by Discriminating Against Patients in Hospitals for Mental Diseases." because that is what it does.

This budget reduction device on page 105 does not apply to persons in hospitals for treatment of heart disease, fractured pelvis, kidney infection, or cancer. It applies only, and discriminatorily, to the mentally ill.

We do not think the Federal Government ought to pick on the mentally ill as an easy target for reducing the Federal budget.

Drs. Gaver and Leopold will describe to you why this particular section is totally discriminatory in nature and intent and how specific controls can be imposed to assure high quality care in lieu of mindless budget cutting.

Now, our amendments are, the first amendment is, to strike the language in the bill discriminating against the treatment of the mentally ill in hospitals for mental diseases.

The second amendment as it applies to the mentally retarded is again simply a budget cutting action with no regard to quality of care.

Drs. Leopold and Gaver will discuss with you the needed controls in this area, which might prevent abuses of the program.

Our third amendment would wipe out a provision as adopted by the House which we consider to be an outrageously shortsighted and discriminatory approach to continuity of care for the mentally ill and mentally retarded.

A program of care is needed at a level below that of a medically-oriented skilled nursing home. For the mentally ill this might be a supportive program of care of a semimedical nature.

For the mentally retarded this might be a supportive program of care of a social-service-rehabilitative type.

Drs. Gaver and Leopold will discuss this with you.

Our fourth amendment to H.R. 17550 concerns the establishment and maintenance of health standards, and we have specified in here the recommendations we have for changes.

Mr. Chairman, this concludes our presentation of recommended amendments.

(Amendments referred to follow:)

Amendment No. 1.—On page 105, line 16, strike the period add a semicolon and add the following language: "except that the above decreases shall not apply in the case of an individual receiving services in a hospital for mental diseases in a State electing to provide services under section 1902(a)(20), if that State provides in its State plan, and has implemented to the satisfaction of the Secretary in the hospital in which the individual is receiving services, methods of assuring utilization review as described in section 1861(k), independent medical audit and program audit, as defined by the Secretary."

Purpose.—Mentally ill over 65 years of age permitted full treatment benefits in "hospital for mental diseases" *providing* State applies specific controls. . . . (*a*) utilization review, (*b*) independent medical audit, (*c*) program audit.

Amendment No. 2.—On page 105, line 3, after the word "year," add a comma and add the following language: "in the same skilled nursing home,"

On page 105, line 4, strike the word "and", and add the following language: "except that the above decreases shall not apply in the case of an individual receiving services in a skilled nursing home if that particular facility has incorporated into its operational program methods of assuring utilization review as described in section 1861(k), and independent medical audit and program audit as defined by the Secretary; and"

Purpose.—Protection of full benefits of mentally handicapped in *skilled nursing homes.*

Amendment No. 3.—On page 107 strike lines 7 thru 11.

Purpose.—*Language* discriminating against States—prohibiting benefits to publicly-operated *"intermediate care facility"* for mentally ill-retarded.

Amendment No. 4.—On page 133, line 21, after the word "agency" add a comma in the following language: "with the approval of the state mental health, mental retardation and developmental disabilities authorities where appropriate,"

On page 134, line 5, delete the quotes and the period, add a comma and add the following language: "except that where mental health, mental retardation and developmental disabilities authorities have already been designated by the State then this paragraph shall not apply".

On page 134, line 19, after the word "personnel" add a comma and add the following language: "and where appropriate for the approval of designated mental health, mental retardation and developmental disabilities authorities,"

Purpose.—Standard-setting and quality-of-care determination by State *"health agencies."* . . . NASMHPD amendment requires approval of *"mental health and mental retardation authorit es."*

Amendment No. 5.—On page 138, line 8, after the word "health" add the following language: "and mental health".

Purpose.—Assurance that "health maintenance organizations" will provide *mental health services.*

Mr. SCHNIBBE. In justification of these amendments, we have asked Dr. Gaver to come from the State of Oregon and Dr. Leopold to come from the State of Vermont to provide for you expert testimony. And they have advised me that they have no objection to interruptions at any time during their presentations.

Thank you, Mr. Chairman, for your courtesy in hearing the State governments on these particular sections of H.R. 17550.

Our first witness, Mr. Chairman, is Dr. Gaver of Oregon.

The CHAIRMAN. Thank you.

Dr. GAVER. Mr. Chairman, I have supplied the committee with copies of my testimony but I shall not repeat it all. I would like to read from certain specific pages.

For example, on page 3, this relates to medical assistance to the aged mentally ill.

The second paragraph, that this program has been successful in the 3 years of its operation is attested to by the rapid decline of mental hospital patients over the age of 65 years.

The next two paragraphs, Dr. George A. Utlett, director of the Missouri Division of Mental Health, indicates that there were 2,175 aged mentally ill persons in Missouri's mental hospitals in June 1967. In June 1970, 3 years later, there were 1,244 persons in residence—a decline of 931 patients, or 43 percent.

A similar situation exists in Oregon. In July 1967, there were 799 aged mentally ill in the mental hospitals. Three years later, in June 1970, there were 412 patients— a decline of 387 patients, or 48.4 percent.

Skipping down two paragraphs, in the last sentence of the sixth paragraph, this decline in the average population of 140 patients was largley due to a decline of the aged mentally ill. Of the 140 patients, 117 were aged mentally ill.

I am dropping down to the next to the last sentence of the next paragraph. In 1963, there were about 1,400 aged mentally ill in the hospitals. In June 1970, there were 412 aged mentally ill in the hospitals. This represents 22 percent of the total hospital population of 1,873, that is in June 1963.

The next sentence I indicate that we are predicting that 2 years from now the percentage of that population will drop to 18.5 percent.

On page 4, the first paragraph, let me read that one paragraph. The number of aged patients receiving medical assistance has declined also. Begining with 410 in July 1967, it rose to a high of 526 the following winter and fell to 269 in the winter of 1969–70 and down to 244 in June 1970. It is estimated that an average of 258 patients will be

recipients each month under this program for 1970-71. The 1970-71 Federal benefits accruing through reimbursement are estimated to be approximately $784,536 for 1970-71 under present law.

Farther down on page 4, I would like to indicate that we carry out all of these 10 points which are part of the necessary control mechanisms:

1. Patients are individually certified and recertified.
2. Adequate medical examinations are conducted and records maintained.
3. Treatment programs are medically determined, and individual treatment plans are established.
4. Quarterly reviews are conducted, and revised treatment plans are filed.
5. Utilization review is in effect.
6. Joint preplacement planning is conducted.
7. Alternate care plans are implemented whenever appropriate.
8. Patients receive $19.50 a month for personal spending allowances.
9. Family financial liability is reduced.
10. Independent medical audit and program audit are conducted.

In the last paragraph on page 5, if H.R. 17550 becomes law, as it stands today in the House version, it is inevitable that patient care will be reduced. The collaborative endeavors between the Public Welfare Division and the Mental Health Division will be diminished. Community placements of the aged mentally ill will be less easily carried out. The patient will bear the burden of diminished service.

Let me turn to page 6 because this deals with a section about which there has been much dicussion, and this is the need or adequate controls on the utilization of these programs.

These controls relate to the quality of service rendered, the extent of utilization of the service, and the cost of the service, and let me read from some of the sections on page 6.

The State Mental Health Directors fully subscribe to the concept of providing treatment instead of custodial care. They concur in proper certification of patients, proper utilization, review, provision of alternative methods of care, and medical audit by an outside team.

It should be recognized, however, that not all treatment is successful, especially in a short time. The aged mentally ill are by nature nearly always long-term, difficult cases. The require disproportionately large amounts of medical-surgical care, long-term medication, often extensive resocialization, and careful preplacement planning. The care thus provided is by nature long term and over an extended period of time. It may also be expensive. This does not make it custodial by definition.

I will skip the next paragraph and go down to the needs for effective controls. The State mental health program directors and their National Association concur, as noted above, in the proper imposition of appropriate controls, including:

1. Certification and recertification.
2. Individual treatment plans.
3. Utilization review.
4. Joint preplacement planning.
5. Utilization of alternate patterns of care.
6. Independent outside medical audit.

The National Association of State Mental Health Program Directors has endorsed the need for all of these mechanisms. They are rational measures to prevent overutilization and improper utilization.

I will not read you the next paragraph except to point out that we do not object to peer review. There are some problems. We can live with that.

The State mental health directors would like to emphasize the need, not only for independent medical audit on an individual case basis, but also for what is referred to as program audit. We find great value in having an independent professional team review the total program of care for the aged mentally ill. Such an audit allows identification of weaknesses of program. It leads to strengthening and improvement of the program. It serves a different function from individual case audit.

The next paragraph, need for effective Federal administration, I will not read that but I want to point to the fact that the State Mental Health Directors concur in the need for effective and adequate Federal administrative procedures and adequate Federal agency personnel if you are going to achieve adequate State administration.

NEED FOR FEDERAL SUPPORT FOR INSTITUTIONAL SERVICES FOR THE MENTALLY RETARDED AND THE INTERMEDIATE CARE FACILITY

We believe Federal support for the intermediate care facility in a public institution is a beneficial use of public funds.

At this point I would like to refer you to exhibit I. You will find this attached. It is entitled "Definition of Institutional Care and Services in Nursing Homes for the Mentally Retarded."

You will note that what this is is a definition of skilled nursing home, a definition of an intermediate facility; breaking the intermediate care facility down into two subtypes, a semiskilled nursing home and another type entitled "Personal Care," which does not involve nursing care.

Oregon is especially concerned at this particular time about the intermediate care facility of the semiskilled nursing home type.

I am going to drop down to the next to the last paragraph on this page. I think it needs to be pointed out.

Less than 1 in 10 of the retarded is resident in public institutions for the mentally retarded. In Oregon, only 2,835, or 8 percent, of its 35,772 retarded persons were in the state institutions in June 1970.

But the ones in the institutions are the most severely regarded, the most handicapped, the least able to reap the fruits of our society. Many of them have complicated medical problems. Orthopedic deformities, epileptic seizures, disorders of metabolism, partial deafness, and speech disorders abound. Many are emotionally disturbed. The behavior of some is self-damaging. Dental deformities, caries, and pyorrhea run rampant without decent medical and dental care.

On the next page, surprisingly, many can live outside an institution if they have the opportunity to receive adequate medical care, physical restoration and physical therapy, habit training, and assistance with self-help skills.

Last year in Oregon, 163 patients were placed in community settings from the hospitals. Follow-up studies show that they are happier and

more satisfied. Fiscal studies indicate that the cost of care was less than in an institution.

Yet, these are the people of America whom H.R. 17550 proposes to disenfranchise by prohibiting Federal reimbursements for their care in a proper and appropriate institutional facility.

As to what is a public institution for the mentally retarded, I am going to drop down to another paragraph, the second paragraph of that section.

The CHAIRMAN. What page are you on?

Dr. GAVER. Page 9, sir, the second paragraph under what is a public institution for the mentally retarded? I want to emphasize that institutions for the retarded are not mental hospitals. They do not care for mentally ill persons. They care for persons who suffer from "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." That is the American Association on Mental Deficiency definition.

They use different methods than do mental hospitals. They use different diagnoses. They focus on different goals. Their concern is to train the mentally retarded person to his maximum level of personal independence and to place him in a community setting if possible.

Dropping down to the next paragraph, a few of the patients will require lifelong supportive care. Some are terribly deformed and capable of only slight self-help.

Dropping down to the next paragraph below on that, the mentally retarded in institutions are often quite young. Exhibit G of this particular presentation shows the age span by decade in Oregon institutions. The peak is in the second and third decade. Fifty percent are severely and profoundly retarded, 34 percent are moderately retarded, and 16 percent are mildly retarded. And I might add that the mildly retarded are generally in the institutions only because they have an additional handicap.

Going to page 10, how much nursing care is needed. I think this is probably the crux of the argument.

Oregon has defined the elements which constitute nursing care as distinguished from the elements which constitute personal care. Exhibit I, I called your attention to this earlier, exhibit I illustrates this definition. Please note that help in bathing, dressing, walking, care of teeth and nails, and security do not constitute nursing care.

Some patients need sufficient nursing care that 24-hour-a-day professional nursing care should be available.

Most patients require some nursing care some of the time. For these persons, professional nursing care must be available at least every day but not on a continuous basis.

The two distinctions described have been the main basis for determining which patients need skilled nursing home care, that is 24-hour-a-day nursing availability, and which need care in an intermediate care facility of the semiskilled nursing type. The amount of nursing care is the determining factor. Those patients who do not need nursing care except for an intercurrent illness do not need care in either a skilled nursing home or an intermediate care facility.

Let me add a word on the semiskilled nursing home type of care.

We do not operate in Oregon intermediate care facilities in public institutions which do not provide nursing care.

Why should there be an intermediate care facility in a public institution? This is page 11, admittedly Oregon has established and is operating intermediate care facilities as distinct parts of its institutions for the mentally retarded. Other distinct parts of those institutions are operated as skilled nursing homes or as a general hospital. Each distinct part is appropriately licensed by the State Board of Health to insure compliance with health and safety requirements. Still other distinct parts of the institutions are operated as facilities to house patients involved in education, training, prevocational training, or work placements.

Oregon's institutions did not automatically qualify for certification. Many months were spent in interagency planning. All patients were individually surveyed for eligibility. All hospitals were surveyed to determine the changes necessary to meet the requirements for licensing as nursing homes.

Special appropriations were obtained. Remodeling was done at a cost of $534,089. After patients were certified, they were moved into the new facilities.

The intermediate care facility, and again we say this is of the semiskilled nursing home type, meets a distinct need for patients who require part-time nursing service. Such patients also require and receive training in self-help skills; communications training, education, physical, occupational, or recreational therapy, and prevocational training...

The public institution meets a need which is at present rarely met in community programs. The need for nursing care simultaneously provided with education, recreational therapy, prevocational training, et cetera, requires an investment in buildings, equipment, and specialized personnel which can seldom be provided in the community-based program except by complicated agreements, a network of transportation facilities, and roving teams of visiting specialists.

Dropping down a couple of paragraphs, comprehensive community services for the retarded will evolve with time. But the time required will be, years, not months. Community-based programs with a full array of services are today a goal, not a reality.

Because of these reasons, public institutions are a necessity. And, when nursing care is part of that needed service, it should be provided. And the mentally retarded person ought to have a right to be considered eligible for the benefits of the social security laws just as much as the patient with severe diabetes, a stroke, or congenital heart disease.

The last part of my testimony, what precise steps did Oregon take? I will just read the numbered portions.

1. The plan was initiated.
2. A decision was made as to skilled nursing home and intermediate care facility.

Nursing home rules and regulations were established. They are present at exhibit K.

Definitions of nursing care were established, exhibit I.

All patients were individually reviewed and certified.

On page 13, six special appropriations were obtained to implement nursing home standards and certification requirements.

The last sentence of that first paragraph, allocations totaling $792,287 represent out-of-pocket expenses.

Going down to 7, reimbursement was commenced for certified patients in licensed and certified facilities effective December 1, 1969.

8. Expanded community programs for the mentally retarded were proposed.

The last of that page, page 13, in Oregon's program, the following elements pertain:

1. Patient care facilities are improved.
2. Patient mdical and nursing care is improved.
3. Placement in alternate care programs is enhanced.
4. Patients have improved access to medical services under the Social Security Act when out of the institution.
5. Patient personnel spending allowances are provided—often for the first time in the patient's lifetime.
6. Family financial liability is reduced or obviated.
7. Program expansion is facilitated.

In summary, in June 1970, there were 2,835 persons resident in Oregon's hospitals for the mentally retarded; 1,431 of these patients were receiving—patients under the social security laws, that is being taken care of—86 were receiving care in skilled nursing homes and 1,345 in intermediate care facilities, a semiskilled nursing home type. The remaining patients do not need such services or are not eligible.

Oregon has developed its plan in the conviction that it was within legal boundaries and was not inconsistent with congressional intent. The participant agencies have expended enormous effort. Legislative concurrence has been obtained, including the funding of program improvements.

This program addresses itself to improving the lot of some of Oregon's most destitute, most handicapped, and most deserving citizens.

On page 15 under recommendations, and this does not detract from the four recommendations already cited by Mr. Schnibbe as to specific amendments:

1. The operation of an intermediate care facility, especially of the semiskilled nursing home type, as a part of a public institution for the mentally retarded should be considered an appropriate use of the facility, within the law, and consistent with administrative interpretation.
2. States which meet the Federal requirements for providing the necessary elements of care within an intermediate care facility should not be penalized because of the disputation that other States have not met the requirements.
3. Adequate certification and utilization controls should be established and enforced. The Federal agency should adopt a definition of nursing care.
4. States should not be left to develop definitions, interpret the laws and regulations, and implement programs in the absence or unavailability of Federal agency assistance. The lack of clarity of the law and the haziness of Federal agency interpretation should not result in disparagement of the states for attempting to put Federal programs to good use.
5. The proposed amendments to section 1121(e) of the Social Security Act as cited on page 107, lines 7 through 11, should be deleted from H.R. 17550.

Thank you, Mr. Chairman, for the opportunity to testify before this committee.

(Prepared statement of Dr. Gaver follows. Hearing continues on p. 531.)

STATEMENT OF KENNETH D. GAVER, M.D., AMINISTRATOR, MENTAL HEALTH DIVISION, STATE OF OREGON, REPRESENTING THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS AND THE STATE OF OREGON

Mr. Chairman and members of the committee, my name is Kenneth D. Gaver. I am Administrator of the Mental Health Division of the State of Oregon. My testimony today is on behalf of the National Association of State Mental Health Program Directors and the State of Oregon. More particularly, it is on behalf of thousands of persons in public institutions who now receive benefits under the Social Security Act and whose benefits would be reduced if Sec. 225 of H.R. 17550 becomes law.

INTRODUCTION

Care of the mentally ill and mentally retarded has been considered a state responsibility since the time of Dorothea Lynde Dix's successful campaign in the 1840s to convince government that these less fortunate human beings required the succor and mercy of their governments.

Congress, too, had the chance to share in the provision of help to these people. I am proud that Congress seized that opportunity—passing in 1854 the "12,225,000 Acre Bill" which authorized a land grant, sales from which would have provided for perpetual care of the mentally ill. The intent of Congress was, however, thwarted by veto of the bill by President Franklin Pierce. His veto message has been lost in antiquity. Apparently, he presumed this to have been of less importance than land grants to railroads, colleges, or western settlers.

Under the present Social Security Laws, the people of America are fortunate in having Federal funds available to pay for the care of the most severely mentally ill and mentally retarded persons in this country. However, H.R. 17550 will go a long way toward undoing the gains thus far made.

A large number of states have implemented the provisions of the Social Security Act as it relates to Medical Assistance for the Aged Mentally Ill—the so-called Long Amendments to the Social Security Act of 1965.

A lesser number of states have implemented the provisions of the Social Security Act as they are applicable to the care of the Mentally Retarded. Several of the larger states, such as California, New York, and Pennsylvania, are utilizing these provisions; as are some of the smaller states, such as Wisconsin and Oregon.

Having acted upon the assumption that approval of their plans by the U.S. Department of Health, Education, and Welfare was consistent with Congressional intent, and having predicted present and future care plans thereon, these states now are faced with the prospect of gross program modifications if changes in the Federal reimbursement limitations are revised downward. The net result to be expected can only be a reduction in the care and treatment of some of this nation's most handicapped, most dependent, and most economically underprivileged citizens.

My comments on H.R. 17550 will deal principally with:

1. Medical Assistance to the Aged Mentally Ill.
2. Need for adequate utilization controls.
3. Need for Federal support for institutional services for the Mentally Retarded and the Intermediate Care Facility.

MEDICAL ASSISTANCE TO THE AGED MENTALLY ILL

My remarks on this subject will be limited. Others have testified, or will testify, on the importance of this program and on the wisdom of retaining the present level of reimbursement.

That this program has been successful in the three years of its operation is attested to by the rapid decline of mental hospital patients over the age of 65 years.

Dr. George A. Ulett, Director of the Missouri Division of Mental Health, indicates that there were 2,175 aged mentally ill persons in Missouri's mental hospitals in June 1967. In June 1970, three years later, there were 1,244 persons in residence—a decline of 931 patients, or 43 percent.

A similar situation exists in Oregon. In July 1967, there was 799 aged mentally ill in the mental hospitals. Three years later, in June 1970, there were 412 patients—a decline of 387 patients, or 48.4 percent.

Studies indicate that Oregon's readmission rate for the aged mentally ill is declining. The length of stay from first admission is declining. The rate of release of the aged mentally ill is so high that the drop in the population is more rapid than it is for all other age groups.

On June 30, 1969, the population of Oregon's hospitals for the mentally ill was 2,020. On June 30, 1970, the population was 1,874. The average population for the month of June 1969 was 2,013 compared to the average of 1,873 in June 1970. This decline in average population of 140 patients was largely due to a decline of the aged mentally ill. Of the 140 patients, 117 were aged mentally ill.

This trend is not entirely new. Exhibit A indicates Oregon's total mental hospital population decline from 5,300 patients in 1958 to 1,873 in June 1970. Exhibit B indicates that admissions are continuing to rise. (Uncharted trends through 1969 and 1970 follow the same pattern.) Exhibit C shows the dramatic drop in the aged population in the hospitals. In 1963, there were about 1,400 aged mentally ill in the hospitals. In June 1970, there were 412 aged mentally ill in the hospitals or 22 percent of the total hospital population of 1,873.

Predictions are that the mental hospital population will decline to 1,364 by June 1973. Only 253 patients, or 18.5 percent of the population, are expected to be aged mentally ill (see Exhibit D).

The number of aged patients receiving Medical Assistance has declined also. Beginning with 410 in July 1967, it rose to a high of 526 the following winter and fell to a high of 269 in the winter of 1969–70 and down to 244 in June 1970. For 1970–71, it is estimated that an average of 258 patients will be recipients each month under this program. The 1970–71 Federal benefits accruing through reimbursement are estimated to be approximately $784,536 for 1970–71 under present law.

Oregon has attempted to meet all the Federal requirements of this program. There are problems, of course; and, from time to time, it is necessary to remind individual physicians or hospitals of the requirements of the program. However, Oregon does point to the following specific points:

1. Patients are individually certified and recertified.
2. Adequate medical examinations are conducted and records maintained.
3. Treatment programs are medically determined, and individual treatment plans are established.
4. Quarterly reviews are conducted, and revised treatment plans are filed.
5. Utilization review is in effect.
6. Joint preplacement planning is conducted.
7. Alternate care plans are implemented whenever appropriate.
8. Patients receive $10.50 a month for personal spending allowances.
9. Family financial liability is reduced.
10. Independent medical audit and program audit are conducted.

Oregon does not operate Extended Care Facilities or Intermediate Care Facilities for the Mentally Ill.

The requirement to pursue the development of a comprehensive community mental health program is being met in Oregon by the growth of community mental health clinics, halfway houses, and special programs. Exhibit E illustrates the growth of funds committed to the community program. Exhibit F demonstrates the increasing comprehensiveness of the clinics. Nursing home placements through the Public Welfare Division are used for community care of the aged.

In July 1970, the Mental Health Division published a report entitled "Proposal for District-Based, State-Operated Mental Health Program in Oregon." This proposal is now being developed into a legislative program, which will greatly expand the community program.

If H.R. 17550 becomes law, it is inevitable that patient care will be reduced. The collaborative endeavors between the Public Welfare Division and the Mental Health Division will be diminished. Community placements of the aged mentally ill will be less easily carried out. The patient will bear the burden of diminished service.

NEED FOR ADEQUATE UTILIZATION CONTROLS

To assure that the Federal Social Security programs are applied most prudently, it is necessary to maintain certain control functions. These relate to quality of service rendered, extent of utilization of the service, and cost of the service.

Treatment versus custodial care

The State Mental Health Directors fully subscribe to the concept of providing treatment instead of custodial care. They concur in proper certification of patients, proper utilization review, provision of alternative methods of care, and medical audit by an outside team.

It should be recognized, however, that not all treatment is successful, especially in a short time. The aged mentally ill are by nature nearly always long-term, difficult cases. They require disproportionately large amounts of medical-surgical care, long-term medication, often extensive resocialization, and careful preplacement planning. The care thus provided is by nature long-term and over an extended period of time. It may also be expensive. This does not make it "custodial" by definition.

Custodial, on the other hand, implies lack of medical, nursing, and rehabilitative services. Modern state mental hospital services are not custodial but, rather, are treatment-oriented to the limit of the resources available.

Need for effective controls

State Mental Health Directors concur, as noted above, in the proper imposition of appropriate controls, including:

1. Certification and recertification.
2. Individual treatment plans.
3. Utilization review.
4. Joint preplacement planning.
5. Utilization of alternate patterns of care.
6. Independent outside medical audit.

The National Association of State Mental Health Program Directors has endorsed the need for all these mechanisms. They are rational measures to prevent overutilization and improper utilization.

State Mental Health Directors would not object to review procedures by outside peer groups. This might be somewhat impractical because of the organizational relationships peculiar to the mental hospital. The mental hospital physician is a member of a structured treatment team. This is a qualitatively different role from the position of the private practitioner who is, in a sense, in the position of serving as a broker for the patient by calling in different paramedical skills on a prescription basis.

The State Mental Health Directors would like to emphasize the need, not only for independent medical audit on an individual case basis, but also for what is referred to as program audit. We find great value in having an independent professional team review the total program of care for the aged mentally ill. Such an audit allows identification of weaknesses of program and problems of integration. It leads to strengthening and improvement of the program. It serves a different function from individual case audit. We commend it to the Committee for inclusion as a quality control mechanism.

Need for effective Federal administration

State Mental Health Directors concur in the need for effective and adequate Federal administrative procedures and adequate Federal agency personnel to provide effective administration. The Directors are often frustrated at the lengthy delays in publication of Rules and Regulations. They also desire to be consulted as to the development of such Rules and Regulations.

Small states, such as Oregon, have felt hampered by the difficulty in obtaining interpretation of Rules and Regulations. This appears to be due to limited numbers of Federal agency personnel fully knowledgeable of the program requirements. Small states have limited staffs available to pursue the intricacies of Federal Laws and Rules and Regulations. The states must rely upon Federal personnel to act as "senior partners."

The states accept plans and reimbursement approval by the Department of Health, Education, and Welfare as indicative of concurrence with Congressional intent. Small states, and even large ones, are not staffed to review extensive committee hearing reports.

NEED FOR FEDERAL SUPPORT FOR INSTITUTIONAL SERVICES FOR THE MENTALLY RETARDED AND THE INTERMEDIATE CARE FACILITY

We believe Federal support for the Intermediate Care Facility in a public institution is a beneficial use of public funds. To explain the reasons requires a quick review of the extent and implications of mental retardation and the kinds of care needed.

Who are the mentally retarded?

Mentally retarded persons are not so different from other persons. They are sons and daughters, brothers and sisters, aunts, uncles, cousins, and even mothers and fathers. Most are poor, very poor. A few are lucky enough to have affluent relatives.

Most retarded persons attend public schools. Most of them grow up to earn their own living. But most also need the helping, guiding hand of a benevolent society. The less fortunate live only because our society believes that all men are created equal and that everyone deserves the right to live and to live with dignity.

How many mentally retarded?

The United States, with a population of over 200 million persons, has about 6 million mentally retarded persons (high estimate).

Oregon, with a population of 2 million, estimates its mentally retarded population at 35,772 persons by a conservative prediction method. Using the same method, there are probably 3,577,000 mentally retarded persons in the United States (conservative estimate).

Less than one in ten of the retarded is resident in public institutions for the mentally retarded. In Oregon, only 2,835, or 8 percent, of its 35,772 retarded persons were in the state institutions in June 1970.

But the ones in the institutions are the most severely retarded, the most handicapped, the least able to reap the fruits of our society. Many of them have complicated medical problems. Orthopedic deformities, epileptic seizures, disorders of metabolism, partial deafness, and speech disorders abound. Many are emotionally disturbed. The behavior of some is self-damaging. Dental deformities, caries, and pyorrhea run rampant without decent medical and dental care.

Surprisingly, many can live outside an institution if they have the opportunity to receive adequate medical care, physical restoration and physical therapy, habit training, and assistance with self-help skills.

Last year in Oregon, 163 patients were placed in community settings from the hospitals. Follow-up studies show that they are happier and more satisfied. Fiscal studies indicate that the cost of care was less than in an institution.

Yet, these are the people of America whom H.R. 17550 proposes to disenfranchise by prohibiting Federal reimbursement for their care in a proper and appropriate institutional facility.

What is a public institution for the mentally retarded?

Fifteen years ago, public institutions for the mentally retarded were called "homes." Today they are sometimes called homes, but they function as training centers and as life support systems.

Institutions for the retarded are not mental hospitals. They do not care for mentally ill persons. They care for persons who suffer from "sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." (AAMD definition)

They use different methods than do mental hospitals. They use different diagnoses. They focus on different goals. Their concern is to train the mentally retarded person to his maximum level of personal independence and to place him in a community setting if possible. If that is not possible, then as full a life as reasonable is provided in the institution—doing productive work and enjoying leisure and companionship.

A few of the patients will require lifelong supportive care. Some are terribly deformed and capable of only slight self-help. The ability to feed oneself, to toilet oneself, or to tie one's shoes may for some be the most that can be hoped for. Some even require nearly total personal care.

The mentally retarded in institutions are often quite young. Exhibit G shows the age span by decade in Oregon institutions. The peak is in the second and third decade. Fifty percent are severely and profoundly retarded, 34 percent are moderately retarded, and 16 percent are mildly retarded.

The administrative arrangements in many states provide that the Mental Health Authority is also the Mental Retardation Authority. In many other states, the administration of mental retardation programs is separate from the administration of mental health programs.

In Oregon, the Mental Health Division administers both programs. There are Assistant Administrators for Mental Health Services and Mental Retardation Services. The organization chart (Exhibit H) displays the structure.

One of Oregon's institutions, Eastern Oregon Hospital and Training Center, has programs for both the mentally ill and the mentally retarded. Common support services are utilized (steam plant, laundry, etc.). But the care programs are different, have different staffs, are in different wards, and are independently administered within the hospital.

Oregon is now moving to implement a comprehensive community program for the retarded. State support of classes for the trainable retarded was initiated in 1969. This school year 630 children will be enrolled in such classes in public and private schools. 4,500 children will be enrolled in classes for the educable retarded in public schools. Community placements are made in foster homes, boarding homes, and nursing homes. Sheltered workshops provide assistance to many retarded persons.

The Mental Health Division plans to expand precare-aftercare services during the next biennium. Homemaker services are to be implemented. Expanded community consultation and evaluation will be available. A subsidy to sheltered workshops will double the services available.

How much nursing care is needed?

Oregon has defined the elements which constitute Nursing Care as distinguished from the elements which constitute Personal Care. Exhibit I illustrates this definition. Please note that help in bathing, dressing, walking, care of teeth and nails, and security do *not* constitute nursing care.

Some patients need sufficient nursing care that 24-hour-a-day professional nursing care should be available.

Most patients require some nursing care some of the time. For these persons, professional nursing care must be available at least every day but not on a continuous basis.

The two distinctions described have been the main basis for determining which patients need Skilled Nursing Home care and which need care in an Intermediate Care Facility. The amount of nursing care is the determining factor. Those patients who do not need nursing care except for an intercurrent illness do not need care in either a Skilled Nursing Home or an Intermediate Care Facility.

Please note that under Oregon's definitions a Home for the Aged is a second type of Intermediate Care Facility. Such a facility does not provide nursing care. Oregon does *not* operate any Homes for the Aged in its public institutions.

Why an intermediate care facility in a public institution?

Oregon has established and is operating Intermediate Care facilities as distinct parts of its institutions for the mentally retarded. Other distinct parts of those institutions are operated as Skilled Nursing Homes or as a General Hospital. Each distinct part is appropriately licensed by the State Board of Health to ensure compliance with health and safety requirements. Still other distinct parts of the institutions are operated as facilities to house patients involved in education, training, prevocational training, or work placements.

Oregon's institutions did not automatically qualify for certification. Many months were spent in interagency planning. All patients were individually surveyed for eligibility. All hospitals were surveyed to determine the changes necesssary to meet the requirements for licensing as Nursing Homes. Special appropriations were obtained. Remodeling was done at a cost of $534,089. After patients were certified, they were moved into the new facilities.

The Intermediate Care Facility meets a distinct need for patients who require part-time nursing service. Such patients also require and receive training in self-help skills; communications training; education; physical, occupational, or recreational therapy; and prevocational training.

The public institution meets a need which is at present rarely met in community programs. The need for nursing care simultaneously provided with education, recreational therapy, prevocational training, etc., requires an investment in buildings, equipment, and specialized personnel which can seldom be provided in the community-based program except by complicated agreements, a network of transportation facilities, and roving teams of visiting specialists.

In our experience, community facilities today may provide one or another of the elements of needed service; but rarely indeed do they provide all the elements of needed service. Today, the public institution must be depended upon to do that complex job.

Comprehensive community services will evolve with time. But the time required will be years, not months. Community-based programs with a full array of services are today a goal, not a reality.

Because of these reasons, public institutions are a necessity. And, when nursing care is a part of that needed service, it should be provided. And the mentally retarded person ought to have a right to be considered eligible for the benefits of the Social Security Laws just as much as the patient with severe diabetes, a stroke, or congenital heart disease.

What precise steps did Oregon take?

1. The plan was initiated.

The State Mental Health and Public Welfare Divisions began plans for implementation in the fall of 1968. Inability to obtain confirming information from Federal agencies delayed the effort for many months. Queries of other states revealed similar frustrations.

A determination was made of feasibility. The Oregon Legislative Assembly passed enabling legislation late in its 1969 session—chapter 507, Oregon Laws 1969 (Enrolled House Bill 1220).

2. A decision was made as to Skilled Nursing Home and Intermediate Care Facility.

A review was made of Public Law 89-97 and Public Law 90-248, as well as relevant regulations as published on June 24, 1969, in the *Federal Register*, Volume 34, Number 120, Part II.

Confirmation of the appropriateness of providing care in an Intermediate Care Facility as part of a medical facility was obtained from the U.S. Department of Health, Education, and Welfare Regional Office in San Francisco. Exhibit J is a copy of the letter confirming Oregon's plan. Note that specific reference is made to the mentally retarded.

3. Nursing Home Rules and Regulations were established.

Exhibit K is a copy of the Oregon State Board of Health Rules, Regulations, and Standards for Nursing Homes for the Mentally Retarded in Oregon, as adopted on October 7, 1969. These rules allow licensing of Nursing Homes which can be certified as Skilled Nursing Homes and Intermediate Care Facilities.

4. Definitions of Nursing Care were established.

Exhibit I clearly defines Nursing Care versus Personal Care as applicable to the mentally retarded. This is an extrapolation from a previously established, but not as inclusive, defintion of Nursing Care.

5. All patients were individually reviewed and certified.

The Mental Health Division supplied the Public Welfare Division with a statistically screened list of patients. Beginning with this list, all eligible patients were individually screened on the basis of legal eligibility, fiscal eligibility, and need for nursing care. Recertification has continued. As of January 30, 1970, 1,567 patients out of a population of 2,960 have been determined eligible. All patients have had initial review. Only new patients or recertifications are now being processed.

6. Special appropriations were obtained to implement Nursing Home standards, certification requirements, etc.

Exhibit L indicates State (Legislative) Emergency Board allocations through March 1970 to the Mental Health Divis[illegible] to implement the program. In addition, on August 22, 1969, an Emergency Fund allocation of $118,483 was made to the Public Welfare Division for additional personnel for this program. Allocations totaling $792,287 represent out-of-pocket expenses.

Exhibit M summarizes the status of licensing of facilities. This summary includes the reduction in total capacity to date of 123 beds with a total licensed capacity of 2,207 beds to meet the needs of 1,567 eligible patients.

It should be noted that the Mental Health Division sought additional funds to improve staffing ratios above those required by the State Board of Health, but action by the Emergency Board was deferred until mid-biennium pending submission of the report of the Oregon Commission on Staffing Standards relative to the SCOPE staffing methodology.

7. Reimbursement was commenced for certified patients in licensed and certified facilities effective December 1, 1969.

8. Expanded community programs for the mentally retarded were proposed.

Exhibit N indicates the direction of expanded services for the mentally retarded. On page 2 of the memorandum, reference is made to the importance of reduced bed capacity resulting from conversion to licensed nursing homes. This plan proposes greatly enhanced alternate care possibilities, as well as programs which will prevent the need of future institutional care.

In Oregon's program, the following elements pertain:

1. Patient care facilities are improved.
2. Patient medical and nursing care is improved.

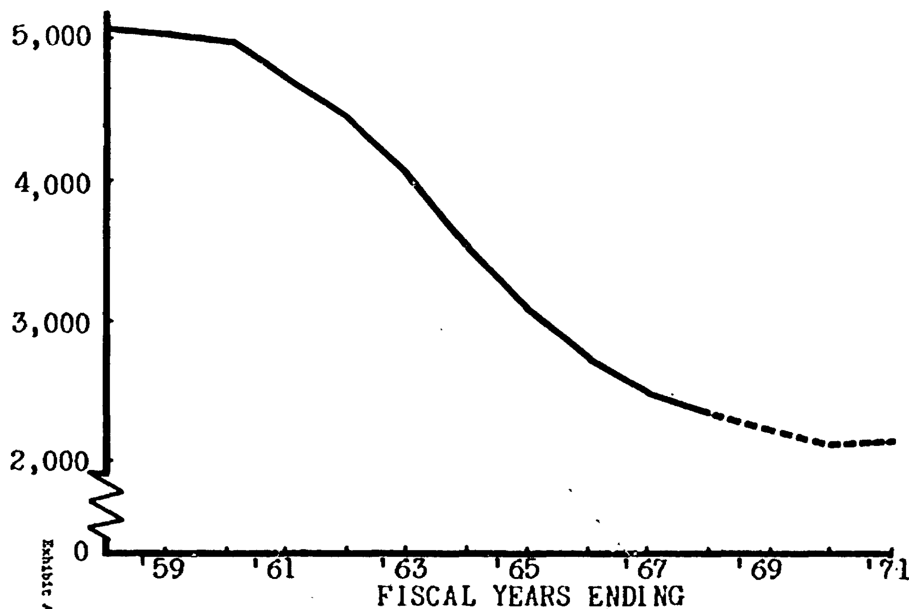
3. Placement in alternate care programs is enhanced.
4. Patients have improved access to medical services under the Social Security Act when out of the institution.
5. Patient personal spending allowances are provided—often for the first time in the patient's lifetime.
6. Family financial liability is reduced or obviated.
7. Program expansion is facilitated.

In June 1970, there were 2,835 persons resident in Oregon's hospitals for the mentally retarded. 1,431 of these patients were receiving Social Security benefits—86 were receiving care in Skilled Nursing Homes and 1,345 in Intermediate Care Facilities. The remaining patients do not need such services or are not eligible.

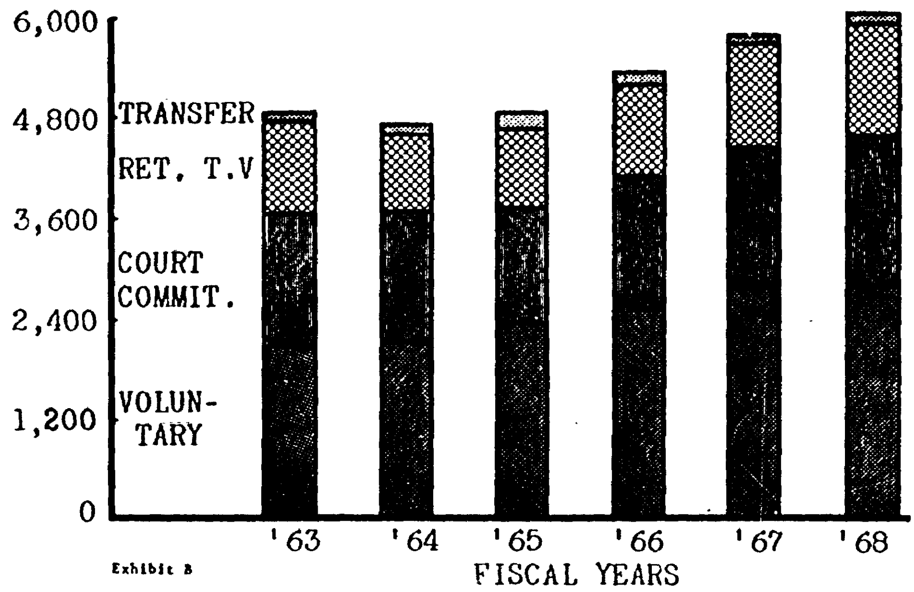
Oregon has developed its plan in the conviction that it was within legal boundaries and was not inconsistent with Congressional intent. The participant agencies have expended enormous effort. Legislative concurrence has been obtained, including the funding of program improvements. This program addresses itself to improving the lot of some of Oregon's most destitute, most handicapped, and most deserving citizens.

RECOMMENDATIONS

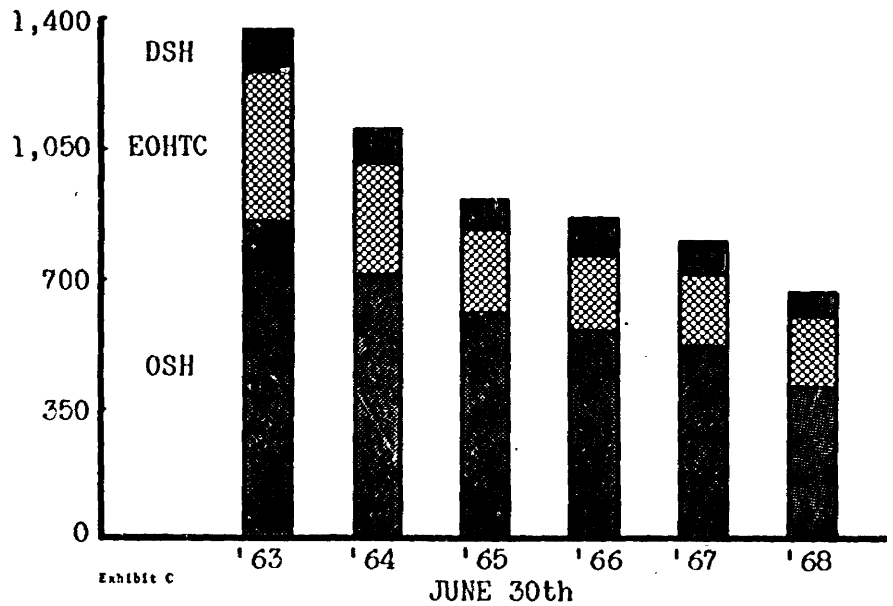
1. The operation of an Intermediate Care Facility as a part of a public institution for the mentally retarded should be considered an appropriate use of the facility, within the law, and consistent with administrative interpretation.
2. States which meet the Federal requirements for providing the necessary elements of care within an Intermediate Care Facility should not be penalized because of the disputation that other states have not met the requirements.
3. Adequate certification and utilization controls should be established and enforced. The Federal agency should adopt a definition of Nursing Care.
4. States should not be left to develop definitions, interpret the laws and regulations, and implement programs in the absence or unavailability of Federal agency assistance. The lack of clarity of the law and the haziness of Federal agency interpretation should not result in disparagement of the states for attempting to put Federal programs to good use.
5. The proposed amendments to Section 1121(e) of the Social Security Act as cited on page 107, lines 7 through 11, should be deleted from H.R. 17550.



PSYCHIATRIC HOSPITALS
TOTAL INTAKE



STATE MENTAL HOSPITALS
INRESIDENT PATIENTS 65 AND OVER



Total Average Daily Population and Patients 65 Years of Age and Over in
Mental Health Division Hospitals for the Mentally Ill,
July 1967 through June 1970 and Projected to June 1973; and
Patients Receiving Public Welfare Division Payments, July 1967 through June 1970

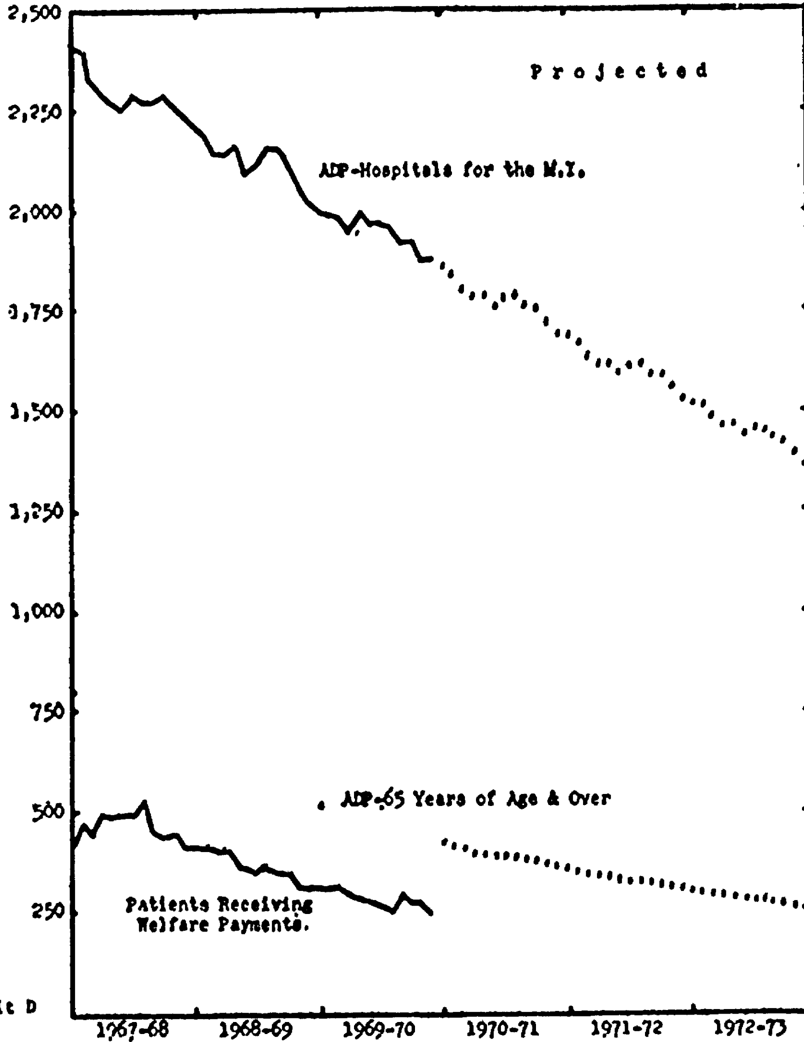


Exhibit D

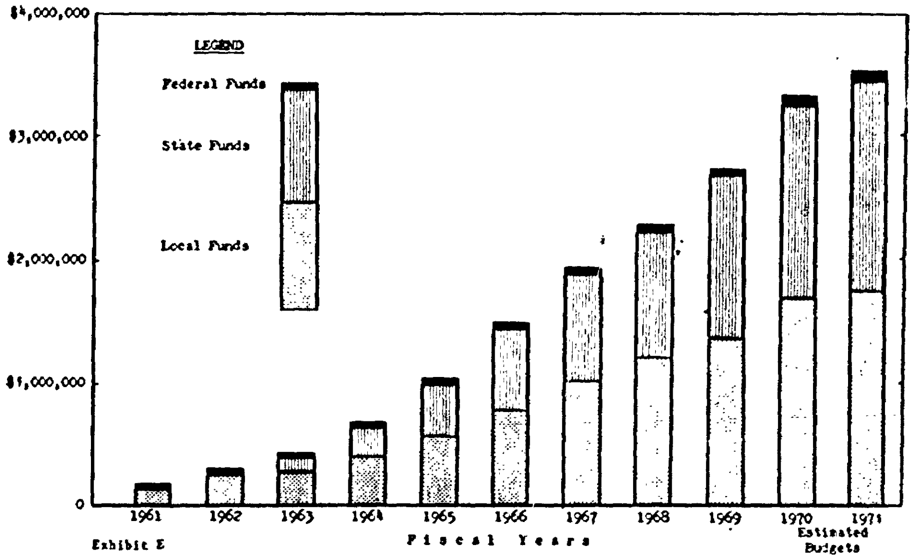


Exhibit E

DIRECT CLINICAL SERVICES PROVIDED BY
OREGON COMMUNITY MENTAL HEALTH PROGRAMS

1962-63: Services Offered — Basic Service, Child Guide, OP Psychiatric, Family Guide, Follow-Up, M. Retardation, Alcohol Ed., Comm. In-P.

1969-70: Services Offered — Basic Service, Child Guide, OP Psychiatric, Family Guide, Follow-Up, M. Retardation, Alcohol Ed., Comm. In-P.

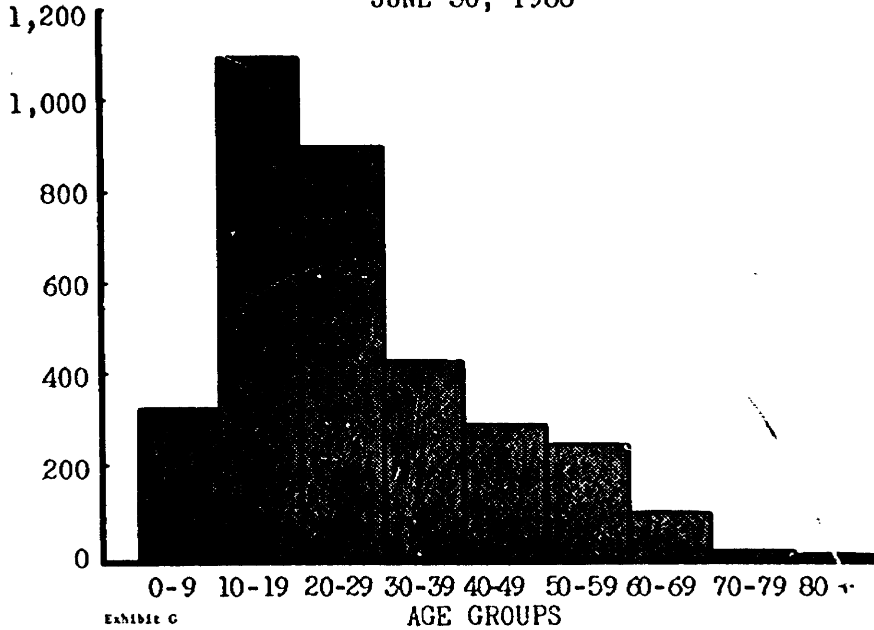
County Clinic:
Baker
Benton
Clackamas
Clatsop
Columbia
Coos
Curry
Douglas
Harney
Jackson
Josephine
Klamath
Lane
Lincoln
Linn
Malheur
Marion
Mid-Columbia
Multnomah
Polk
Tillamock
Tri-County
Tualatin Valley
Umatilla-Morrow
Union
Yamhill

Number of Services (1962-63): [illegible] [illegible] [illegible] 5 - 13 1 -

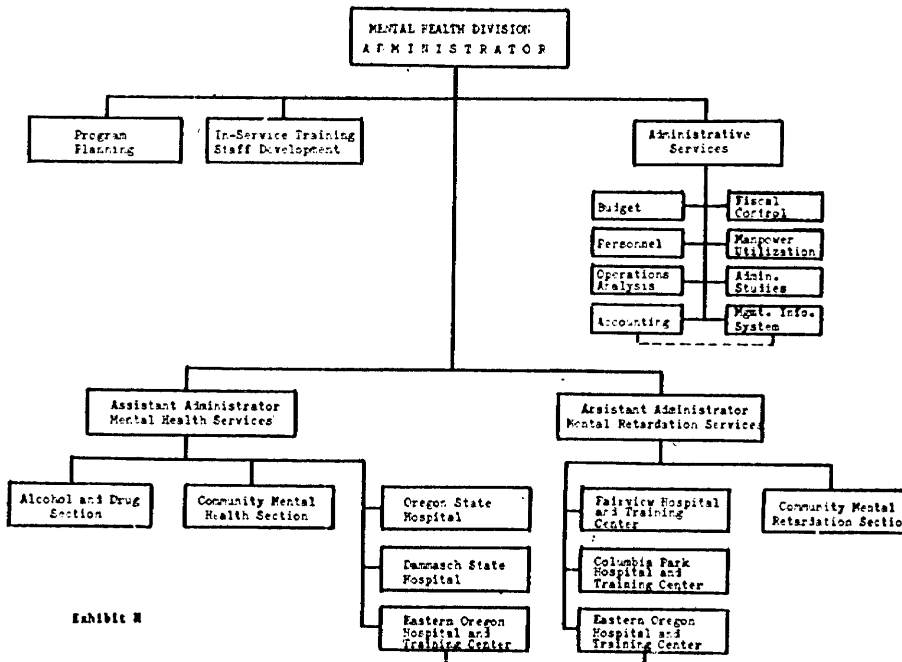
Number of Services (1969-70): [illegible] [illegible] [illegible] [illegible] [illegible] 17 12 1

Exhibit F

HOSPITALS FOR THE MENTALLY RETARDED AGE DISTRIBUTION OF INRESIDENT POPULATION JUNE 30, 1968



MENTAL HEALTH DIVISION ORGANIZATION CHART



Definition of Institutional Care and Services in Nursing Homes for Mentally Retarded, Oregon Public Welfare Division

A. Definition of Level of Care

1. *Skilled Nursing Home Care.*—Characterized by the need for and availability of full-time nursing services as set forth in this guide plus required personal services in a facility licensed as a nursing home for mentally retarded under state law and which meets all criteria for a skilled nursing home as set forth in this guide.

2. *Intermediate Care Facility.*—Is an institution or a distinct part thereof, which is licensed under state law and meets the requirements for ICF set forth in this guide. Care provided in an Intermediate Care Facility could be characterized as follows:

a. *Semi-Skilled Nursing Home Care.*—Characterized by required availability of professional nursing personnel on less than a full-time basis and full-time aides with a formal course in training for care of mentally retarded plus necessary personal services in nursing home beds licensed for care of mentally retarded.

b. *Personal Care.*—Characterized by the provision of personal services in a facility licensed for care of mentally retarded.

B. Services Requiring Professional Nursing Administration or Supervision

Note: This does not mean trained sub-professionals and aides cannot perform these duties in facilities or that these cannot be done by trained relatives in a home situation under proper supervision.

1. Oxygen or Inhalation therapy.
2. Urine testing for sugar, acetone, etc.
3. Surgical dressings (sterile technique).
4. Nursing treatments.
5. Medication administered hypodermically (intramuscularly or intravenously).
6. Enema.
7. Intravenous feeding.
8. Intake/output chart maintenance.
9. Care of indwelling catheter (including irrigations).
10. Colostomy or ileostomy care.
11. Care of total bed patients to provide preventive and therapeutic care relating to skin care and contractures as well as lifting to and from chair at intervals when possible, proper positioning, etc.
12. Care of incontinence when required for treatment of skin problems or other infections and reporting changes in continency or incontinency pattern which may alert physician to other medical problems.
13. Treatment of persistent conditions such as boils, acne, scabies, fungus, etc.
14. Skilled observation of side effects of medication to assist physician in determination if reaction is dose-related, due to individual patient sesitivity or due to patient's special medical problems. This would include neuromuscular reactions, motor restlessness, dystonias, pseudoparkinsonism, edemas, blood pres-behavior, etc. The reporting of these observations to be referred to the physician sure, or heart rhythm irregularities, skin disorders, jaundice, recurrent psychotic behavior, etc. The reporting of these observations to be referred to the physician for treatment adjustments or change.
15. Planned training and teaching self-help such as performing bodily functions (bowel and bladder control), speaking, walking, dressing, self-feeding. socializing skills, personal hygiene, learning basic commands, use of prosthetic devices.
16. Regular checking of patients whose behavior results in self-abuse and injury such as inserting objects in body orifices, picking at self, head banging, etc.
17. Control and modification of the following kinds of on-going and recurrent behavior:
    1. Assaultive or combative
    2. Withdrawn
    3. Destructive
    4. Sexually aggressive

18. Planned service to prevent contractures and musculoskeletal deformities or to ease those conditions already existing.

19. Help in eating for those patients who have masticating and/or swallowing problems. Plans for these patients should be recorded and available for all nursing personnel.

20. Carry out plans for opportunity and continued activity of patients in maintaining level of function.

C. PERSONAL SERVICES NOT REQUIRING AVAILABILITY OF PROFESSIONAL NURSING PERSONNEL FOR ADMINISTRATION OR SUPERVISION

1. Help in bathing.
2. Help with dressing and/or undressing.
3. Help with personal care, i.e., care of teeth, hair, nails, and skin.
4. Security (supervision to insure personal safety).
5. Help with ambulation.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
San Francisco, Calif., August 28, 1969.

Mr. ANDREW F. JURAS,
Administrator, State Public Welfare Commission,
Salem, Oreg.

DEAR MR. JURAS: This letter will confirm the comments in your July 23, 1969, letter regarding payments in behalf of mentally retarded individuals in skilled nursing homes and intermediate care facilities. As a result of the PREP team discussion on August 4, 1969, you, no doubt, have the confirmation needed, and, hopefully, your questions answered. We would like to use this letter as a means of bringing our files up to date as well as reconfirming our discussions.

Those present at the discussion on August 4th were:

Art Wilkinson, Fiscal Analyst, Executive Department, Public Welfare and Mental Health;
Ken Gaver, M.D., Director, and
J. D. Bray, M.D., Deputy Director, Mental Health Division;
Robert Heilman, M.D., Director of Licensing and Standards, State Health Department;
Clarence Jenike, M.D., Deputy State Public Health Administrator;
Mr. Juras, Dr. Domke, and Mr. Arbuckle from Welfare Division; Messrs. Muth, Marrinan, Barker, Burr, Woffinden, and Dr. Vander Slice from the PREP team.

It was determined that all aspects of licensing are entirely determined by the State. If you wish to write regulations specifically for nursing homes for mentally retarded, this would be a State decision. If these nursing homes are to be included in Federal programs, however, they must meet all applicable Federal standards and requirements.

It was also determined that payments could be made to an I.C.F. which is a distinct part of a public institution, as long as it is a *medical* institution.

Finally, it was determined that no special provisions are required in the State Plan to include mentally retarded individuals. The fact that a person is or is not mentally retarded has no bearing in and of itself on the eligibility under either program. It will be necessary to include the new licensing standards, however.

We hope this letter is in sufficient detail to adequately confirm our discussions. Should you have any further questions, please let us know.

Sincerely,

(Miss) GENE BEACH,
Associate Regional Commissioner.

RULES, REGULATIONS AND STANDARDS FOR NURSING HOMES FOR THE MENTALLY RETARDED IN OREGON

[Editor's Note: Unless otherwise specified sections 23-330 through 23-368 of this chapter of the Oregon Administrative Rules Compilation were adopted by the Board of Health October 7, 1969 and filed with the Secretary of State

October 9, 1969, as Administrative Order HB 226. Effective October 9, 1969].

23-330 Definitions. (1) A "Nursing Home for the Mentally Retarded" means any institution or health care facility which:

(a) Operates and maintains facilities and a wide range of services exclusively for two or more mentally retarded residents in whom there is subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

(b) Provides one or any combination of classes of care as defined in section 23-346 (6) (a) through (e) of these rules.

(2) "Hospital Licensing Law" means ORS 441.005 to 441.080.

(3) "Board" or "State Board of Health" means the Oregon State Board of Health.

(4) "Registered Nurse" means a person graduated from an accredited school of nursing and currently registered through the Oregon State Board of Nursing.

(5) "Licensed Practical Nurse" means a person licensed through the Oregon State Board of Nursing as a practical nurse.

(6) "Nursing Aide" means a person working under the direct supervision of a registered nurse or a licensed practical nurse.

23-332. Application for License. All persons contemplating the operation of a nursing home for the mentally retarded shall apply to the Board for a license on a form provided by the Board and remit the license fee required by law at least 30 days before the opening of the nursing home.

23-334. Issuance of License. (1) An applicant must be of reputable character and suitable temperament and understanding of the needs of mentally retarded individuals and how and what services and programs are necessary to meet these needs.

(2) If the institution applying for a license is a governmental institution, no license fee for the facility will be required; however, to qualify for licensure as a nursing home for the mentally retarded the facility must be operated in accordance with all the requirements of ORS 678.510 to 678.990. This would require the payment of a nursing home administrator's fee.

(3) Every nursing home for the mentally retarded shall have a distinctive name which is to be used in applying for a license and shall not be changed without first notifying the board in writing.

(4) Each license shall specify the maximum allowable number of beds on each floor of each building comprising the nursing home for the mentally retarded. It shall also state the classes of care the facility will provide.

(5) A separate license shall be required for each nursing home for the mentally retarded when more than one nursing home for the mentally retarded is operated under the same management; provided, however, that separate licenses are not required for separate buildings on the same grounds used by the same nursing home for the mentally retarded.

(6) The license shall be conspicuously posted in the office where residents are admitted.

(7) No person or institution licensed pursuant to the provisions of ORS, Chapter 441, shall in any manner or by any means assert, represent, or imply that such person or institution is or may render care or services other than that which is permitted by or which is within the scope of the license issued to such person or institution by the Board.

23-336 Expiration and Renewal of License. (1) Each license to operate a nursing home for the mentally retarded shall expire on June 30th following the date of issue, and if a renewal is desired the licensee shall make application at least 30 days prior to the expiration date upon a form prescribed by the Board.

(2) Each nursing home for the mentally retarded shall submit an annual report which shall be upon a form prescribed by the Board.

(3) When an applicant has failed to obtain a license because of non-compliance, an application for the new licensing year shall be considered as a new application rather than a renewal.

23-338 Denial or Revocation of License. A license may be withheld or denied or revoked if the Board finds upon investigation that any illegal act affecting the welfare of a resident in the nursing home for the mentally retarded has been permitted, aided or abetted by the person or persons in charge of the home, or by either of them.

23-340 Return of License. Each license certificate in the licensee's possession shall be returned to the Board immediately on the suspension or revocation of the license, or if the operation is discontinued by the voluntary action of the licensee.

23-342 Submissions of Plans. (1) Prior to construction of a new building or an addition to an existing building or remodeling of an existing building, plans drawn by an architect or plans drawn to scale (using the standard ¼" or ⅛" scale) with the appropriate architectural symbols, shall be submitted to the Board for approval with respect to compliance with these standards.

Note: The Board recommends that all construction conform to the standards found in the latest edition of the Uniform Building Code as adopted by the Pacific Coast Building Officials Conference.

(2) The water supply, plumbing, sewerage and garbage disposal systems shall be approved by the State Plumbing Division and the County Sanitarian.

23-344. Location and Communication. (1) Location and accessibility should be considered in planning new nursing home for the mentally retarded facilities.

(2) Telephones to summon help in case of fire or other emergency, shall be adequate in number and shall be so located as to be quickly accessible from all parts of the building.

23-346. Building (1) Buildings to be used as nursing homes for the mentally retarded shall be suitable for such usage. They shall be subject to approval of the Board, and must comply with the building codes of local municipalities and county planning and building permits.

(2) The walls and floors shall be such as to permit frequent washing or cleaning and the stairs shall be covered with a non-skid material. The building shall be kept clean and sanitary and in good repair, and vector free. Kitchen, bathrooms and utility rooms shall have smooth enameled or equally washable surfaces.

(3) All stairways shall be provided with handrails.

(4) Each resident's room or ward area shall be an outside room or area.

(5) Individual's sleeping quarters shall be of sufficient size to allow for adequate service and nursing procedures and to permit the placing of beds at least three feet apart.

(6) The size of the service areas and sleeping areas will be determined by the level of care required and applicable to the classifications as follows:

(a) Class I Nursing Home for the Mentally Retarded. In this category are residents without physical disabilities and no behavior problems and minimum mental retardation. These residents are potential candidates for vocational rehabilitation and return to a community environment. As such the environment should be normalized to include the following:

(A) Not more than four residents to a ward.

(B) The ward to have 70 square feet per bed with a chair and either a separate clothes locker or a common clothes closet for the ward residents.

(C) Residents in this group shall also have a day area based on twenty square feet per resident. This area may also serve for other activities such as recreation, dining or education.

(D) Toilets serving residents in this category shall have toilet seats, be enclosed with a door and in ratio of one toilet per 15 residents and one lavatory per 10 residents. If male and female residents are housed together, separate toilets and lavatories for male and female residents are provided.

(E) The window area of the four-bed wards shall be no less than one-tenth of the floor area.

(F) There shall be one tub and shower for every 30 residents.

(G) Paraphanelia for good grooming such as mirrors, combs, brushes, tooth brushes, etcetera shall be available.

(H) Residents up to age 10 may be housed together and share common toilet and bathing facilities. Over age 10, the sexes shall not be mixed and separate toilet and bathing facilities shall be provided for each sex. In each resident case, a physician evaluation shall be required for proper placement.

(b) Class II Nursing Home for the Mentally Retarded. Individuals in this grouping are similar to Class I except the degrees of mental retardation are greater and maximum program objectives are aimed at placing the resident in a sheltered environment. Environmental factors such as room sizes, bath rooms, et cetera would be the same as Class I.

(c) Class III Nursing Home for the Mentally Retarded. Individuals in this grouping age severely mentally retarded with little or no behavior problem or physical disibilities. Educational Efforts shall be directed to the development of self-help skills. Often groups under the age of puberty with both boys and girls in residential wards are programmed together in the development of self-help skills, group interrelationship, et etcera. This shall apply to all children in all age groups.

In this class larger wards up to 30 beds per unit are required with one bath tub and shower for every 30 residents. There shall be one toilet and lavatory for every 15 residents. The bed space in the ward shall not be less than sixty square feet per bed and the window area one-tenth the floor area of the ward. There shall be a day area of 30 square feet per resident to serve as a multi-purpose area.

(d) Class IV Nursing Home for the Mentally Retarded. Mentally retarded residents in this group may be autistic, and/or have acting-out behavior prob-but would require organized therapy mainly. Ward and space requirements as lems. The residents would not necessarily fit into any organized training program well as toilet and lavatory requirements for Class III nursing homes for the mentally retarded are applicable to this group. There shall be 30 square feet per resident to serve as a multi-purpose room.

(e) Class V. Nursing Home for the Mentally Retarded. Residents in this group are severely physically handicapped. This group requires the greatest concentration of professional staffing due to the complex problems in the group. In this class there shall be bath tables in the bathroom in addition to the tubs and showers. The ratios of one tub, one shower and one bath table for every 30 residents, with open toilets one to every 15 residents shall be required for this group. There shall be one lavatory for every 15 residents, in the bathroom. The bed space in the ward shall not be less than sixty square feet per bed and the window area one-tenth the floor area of the ward. There shall be a day room of 30 square feet per resident to serve as a multi-purpose area.

(7) Auxiliary space for a day room, bathrooms, dining rooms, isolation facilities, utility rooms and nurses stations shall be required.

(8) There shall be no signal systems, draw curtains, screens, bedside tables or overhead bed lamps required in any class nursing home for the mentally retarded. The rooms or wards of all classes may have curtains, wall decorations and room furniture.

(9) Smoking shall be permitted only in a controlled environment and the proper safety precautions shall be observed.

(10) Lighting shall be at least five foot-candles of light in hallways, ramps, and stairways, and 20 foot-candles of light at the nurses' station, administrative offices, utility rooms, and at least 10 foot-candles of light in the day rooms and wards. Exposed light bulbs visible to the residents' eyes are prohibited.

(11) Each class nursing home for the mentally retarded shall have utility or work rooms, clothing rooms, linen closets, janitors' closets, and day rooms. In addition, Classes I, II and III shall have an administrative office, and Classes IV and V shall have a nurses' station.

(12) The building shall at all times be adequately ventilated. Kitchen, bathrooms, and service rooms shall be so located and ventilated by windows or mechanical means as to prevent offensive odors from entering residents' rooms and the public halls.

(13) The heating plant shall be capable of maintaining a temperature of 75 degrees Fahrenheit in all rooms used for residents, whenever that temperature is necessary for the resident's comfort.

(14) An isolation room having at least 80 square feet with a toilet and lavatory shall be provided to control communicable diseases.

(15) A general storage area shall be provided.

(16) The janitors' closet adjacent to one or more wards shall contain a utility sink with hot and cold running water. The closet shall be mechanically ventilated to the outside.

(17) An adequate number of toilet rooms, conveniently located and separate from those used by residents, shall be provided for personnel.

23-348. Codes. The facility shall operate in conformity with state laws governing fire safety, plumbing and sanitation. All local ordinances are also applicable.

23-350. Accommodations for Residents. (1) All residents shall be provided with a suitable acceptable standard bed, crib or pediatric bed according to the needs of the residents. Satisfactory sanitary covers shall be used for all mattresses.

(2) Residents in Classes I, II and III nursing homes for the mentally retarded shall have their own items of personal use such as tooth brushes, glasses, et cetera.

(3) Bedpans in Classes IV and V nursing homes, for the mentally retarded are required according to need.

23-352. Personnel. (1) Each nursing home for the mentally retarded shall have a licensed nursing home administrator as licensed under ORS 678.510 to 678.990. One licensed administrator shall suffice for all five classes of nursing homes for the mentally retarded if they are all a part of the institution. Any nursing home for the mentally retarded providing just one class of care would be required to employ a licensed administrator.

(2) Staffing for the five classes of nursing homes for the mentally retarded shall be on the basis of total manpower needs.

(3) There shall be a director of nurses having overall supervision of the care and treatment of residents. The following additional staffing requirements shall be met:

(a) Classes I and II nursing homes for the mentally retarded shall have a nursing aide in charge of each shift as well as one nursing aide for every 15 residents. The nursing aide in charge of a shift may serve as the nursing aide requirement for every 15 residents.

(b) Class III nursing homes for the mentally retarded shall have a registered nurse on duty 40 hours per week on the day shift and a licensed practical nurse on duty for each of the other shifts. In addition there shall be one nursing aide for every 10 residents.

(c) Class IV nursing homes for the mentally retarded shall have 24 hours of registered nurse service each day of the year as well as one nursing aide for every 7 residents. Licensed practical nurses may be employed as charge nurses if necessary.

(d) Class V nursing homes for the mentally retarded shall have 24 hours of registered nurse service each day of the year as well as one nursing aide for every 5 residents. Licensed practical nurses may be employed as charge nurses if necessary.

(4) If indicated by programming, additional specialists shall be employed to handle problems concerned with communication (speech and audio); recreation (community and individual); and a vocational and work program, psychological, psychiatric and social service. In addition, the necessary medical specialties and dental services shall be made available.

(5) An educational program (formal) if a part of the overall program in the facility shall employ qualified special education teachers for the mentally retarded.

(6) There shall be an appropriate number of cooks, kitchen helpers and food servers to provide a regular acceptable dietary service including special diets.

223-354. Care of Residents. (1) All residents admitted to any class nursing home for the mentally retarded governed by these rules and regulations shall be under the care and supervision of a person licensed to practice medicine by the Board of Medical Examiners of the State of Oregon.

(2) All residents admitted to a nursing home for the mentally retarded shall have been previously examined, both physically and mentally, and a written program of care and treatment prepared outlining the goals attainable. This preplacement procedure shall designate the skills and services needed for the rehabilitation and care of the resident. Placement shall be made in a facility providing the skills and services required.

(3) All residents in Classes III, IV and V nursing homes for the mentally retarded shall have a daily bath and a complete change of clothing. Residents in Classes I and II nursing homes for the mentally retarded shall have a bath according to their needs.

(4) No resident shall at any time be admitted to a bed in any room other than one regularly designated as a bedroom or ward.

(5) No towels, wash cloths, both blankets, or other linen, which comes directly in contact with the resident, shall be interchangeable from one resident to another unless it is first laundered.

(6) Restraints shall be applied only when they are necessary to prevent injury to the residents or to others, and only upon the written order of the physician, and shall be used only when alternative measures are not sufficient to accomplish their purposes. Careful consideration shall be given to the methods by which they can be speedily removed in case of fire or other emergency.

(7) No bar or lock shall be permitted on any door of any room where residents are confined or housed unless such lock or bar is a type approved by the State Fire Marshal, can be readily and easily opened from the corridor side without the use of a key, and does not require any special knowledge to operate.

(8) The owner or licensed administrator of a nursing home for the mentally retarded shall immediately inform the Oregon State Board of Health when any registered nurse or licensed practical nurse employed by the nursing home for the mentally retarded is terminated or resigns her position.

23-356. Sterilization of Instruments, Equipment and Supplies.

(1) Wash basins, mouth wash cups, drinking glasses, and bedpans shall be sterilized on the resident's dismissal.

(2) Thermometers shall be sterilized between each use.

(3) Equipment shall be provided for the proper sterilization of dressings, utensils, instruments, solutions and water.

(4) A nurses' station and medicine dispensing area equipped with sink, hot and cold running water shall be provided.

23-358. Storage and Disposal of Drugs. (1) All drugs shall be plainly labeled and stored in a specially designated medicine cabinet, closet or storeroom and be made accessible to authorized personnel only. Such cabinet, closet or storeroom must be well illuminated and key locked in the absence of persons who are properly permitted access.

(2) Old medications, including special prescriptions for residents who have left the nursing home for the mentally retarded shall be disposed of by incineration or other equally effective method except narcotics which will be handled in the manner prescribed by the U.S. Narcotic Bureau.

23-360. Control of Infectious Contagious and Communicable Diseases. (1) Facilities and proper procedures for the prevention and control of infectious, contagious and communicable diseases, shall be provided and strict compliance with the rules of the Board for the control of communicable diseases shall be required. Admission of residents suffering from such diseases must have the approval of the Local Health Officer or the State Health Officer.

(2) Facilities and proper arrangements of departments, rooms and residents' beds shall be provided for the prevention of cross infections and the control of infectious, contagious and communicable diseases, which shall include provisions for the removal of infectious cases to a location where proper isolation can be carried out.

(3) Proper isolation procedures for all personnel for the control and prevention of cross infections between residents, department and services in the nursing home for the mentally retarded shall be established.

(4) After the discharge of any resident, the bed, bed furnishings, bedside furniture and equipment shall be thoroughly cleansed prior to re-use. Mattresses shall be professionally renovated when necessary.

(5) The regulations of the Board relating to tuberculosis examinations for care facilities personnel and admittees, OAR Chapter 333, Section 26-005 to 26-025 shall be applicable.

(6) All residents shall be immunized and vaccinated for smallpox, diphtheria, tetanus, measles, polio and pertussis. In addition when indicated, immunization against influenza shall be required.

23-362. Sanitary Precautions. (1) All garbage and refuse shall be stored and disposed of in a manner that will not create a nuisance or a public health hazard.

(2) When community garbage collections and disposal service is not available, garbage shall be either thoroughly incinerated, buried in a pit and covered with two feet of earth, or disposed of by some other equally effective and sanitary method.

(3) Garbage and refuse receptacles shall be durable, water-tight, insect and rodent proof, and shall be covered with a tight-fitting lid. Garbage receptacles shall be kept covered at all times, except when the lid is removed for temporary use, and shall be cleansed and disinfected after each emptying.

(4) Soiled surgical dressings and other similar wastes shall be incinerated or shall be disposed of by some other equally effective and sanitary method. Approved incinerators shall be used when adequate commercial garbage service is not available.

(5) During the season when flies, mosquitoes, and other insects are prevalent, adequate measures shall be taken to prevent their entry through doors, windows or other outside openings. Where screens are used there shall be not less than 16 meshes per lineal inch, and all screened doors shall be equipped with self-closing devices.

(6) The serving of raw milk is prohibited.

(7) No employee shall resume work after using the toilet without first washing his hands.

23-364. Handling of Food. (1) Nursing homes for the mentally retarded shall meet the requirements of the State of Oregon Sanitary Code for Eating and Drinking Establishments insofar as they relate to facilities, preparation, and service of food to residents.

(2) At least three meals shall be served daily, and supplemental nourishment and special diets shall be provided as needed. Meals shall be nutritionally adequate and attractively served, according to approved dietary standards. Accurate records of the menus for all meals in the previous week shall be preserved and made avilable for inspection to representatives of the Board.

(3) Storerooms shall be clean and well ventilated. All foods shall be so stored as to be protected from dust, flies, rodents, vermin, unnecessary handling, droplet infection, overhead leakage, or other source of contamination.

(4) Kitchen facilities shall include refrigerator and perishable food must be kept at a temperature below 50 degrees Fahrenheit in order to prevent deterioration. A reliable thermometer shall be provided in the refrigerator and in storerooms used for perishable food.

(5) Every water glass-filling device shall be so constructed as to prevent any contact of the upper one-third of the glass with the device, and so that no portion of the device extends into the glass.

(6) All dishes and glassware used in the serving of food and drink to residents shall be effectively cleaned and disinfected after each individual use. Gross food particles shall be removed by careful scraping and prerinsing in running hot water. Brushes, baskets, and sprays are suggested. The dishes shall be thoroughly washed in hot water, 110 degrees Fahrenheit to 120 degrees Fahrenheit, using an adequate amount of effective soap or detergent. Following this, the utensils shall be rinsed in hot water to remove soap and disinfected by one of the following methods:

(a) Immersion for at least two minutes in clean water at 170 degrees Fahrenheit.

(b) Immersion for at least one-half minute in boiling water; or

(c) Immersion for at least two minutes in a lukewarm chlorine bath containing at least 50 parts per million of available chlorine.

Note: Chlorine is not recommended for silverware. It is pereferable to use either (a) or (b) above.

If steam, or hot-water cabinets, or dish-washing machines are used, the results must be equal to those obtained by the methods outlined above. After disinfection, the utensils shall be allowed to drain and dry in racks or baskets on non-absorbent surfaces. Drying cloths are not recommended. Dishes shall be stored in closed cupboards for protection against dust, moisture, et cetera.

(7) All ice used in contact with food or drink shall be from a satisfactory source, and handled and dispensed in a sanitary manner.

23-366. Safety and Emergency Precautions. (1) The regulations of the State Fire Marshal shall be met before the nursing home for the mentally retarded may be issued a license.

(2) Emergency lighting facilities shall be provided and distributed so as to be readily available to personnel on duty. Battery operated lamps providing service for at least thirty minutes shall be in readiness.

EXHIBIT L

COSTS TO MEET LICENSING PROGRAM

HOSPITALS FOR THE MENTALLY RETARDED

	FHTC	CPHTC	EOHTC	Total
A. To meet board of health licensing requirements	$364,835	$157,349	$34,000	$556,184
(Portion related to fire safety)	(284,399)	(105,390)	(34,000)	(423,789)
B. To meet certification by public welfare		6,100	7,662	13,762
C. To meet certain administrative costs	66,287	16,444	8,525	91,256
D. To meet SCOPE-determined staffing recommendations				
E. To speed remodeling of Withycombe Cottage	12,602			12,602
Total	443,724	179,893	50,187	673,804

EXHIBIT M

LICENSING OF FACILITIES

Facility	Emergency board	License	Original beds	Increase (+) or decrease (−)	Licensed beds	B/H class	PWD type	Eligible Jan. 1, 1970
Columbia Park Hospital & Training Center								283
May 1	Nov. 14 and Dec. 19	Jan. 19, 1970	84	+3	87 III	SS		
May 2	do	Dec. 1, 1969	84	+3	87 III	SS		
May 3	do	do	90	−3	87 III	SS		
Heath 3	do	do	47	−12	35 III	SS		
Fritchett	do	do	50	−8	42 III	SS		
Subtotal			355	−17	338			
Eastern Oregon Hospital and Training Center								409
A-1	Dec. 19, 1969	Jan. 2, 1970	25	0	52 IV	SS		
A-2	do	do	52	0	52 IV	SS		
A-3	do	do	44	0	44 V	SK		
A-4	do	do	44	0	44 IV	SS		
B-1	do	do	52	0	52 IV	SS		
B-2	do	do	40	0	40 V	SK		
B-3	do	do	44	0	44 V	SK		
B-4	do	do	44	0	44 IV	SS		
C-3	do		52	−11	41 IV	SS	C-3	
C-4	do	Jan. 2, 1970	52	−5	47 IV	SS		
Subtotal			476	−16	460			

Fairview Hospital & Training Center								875
Gaines	Feb. 20	Mar. 1	100	−12	88	III	SS	
Kozer	do	do	56	0	56	III	SS	
Lane	do	do	100	−12	88	III	SS	
LeBreton	do	do	[1] 96	−19	77	III	SS	
Magruder	do	do	100	−7	93	III	SS	
Smith	do	do	80	0	80	III	SS	
Holderness	do	do	101	−7	94	III	SS	
Pierce	Dec. 19	Jan. 2	88	−26	62	III	SS	
Withycombe	do	Sept. 1, 1970 [2]	71	0	71	III	SS	
Meier	Dec. 19 and Feb. 20	Jan. 2 and Mar. 1	91	0	91	IV	SS	
Prigg	do	do	211	−7	204	IV	SS	
Benson	Feb. 20, 1970	Mar. 1	99	0	99	V	SS	
Byrd, ward 4	Dec. 19	May 1	34	0	34	V	SK	
Byrd, ward 5	do	do	34	0	34	V	SS	
Byrd, OSH	Feb. 20	Mar. 1	88	0	88	V	SS	
Patterson	Dec. 19 and Feb. 20	Jan. 2 and Mar. 1	150	0	150	V	SS	
Subtotal			1,499	−90	[3] 1,409			
Grand total			2,330	−123	2,207			1,567

[1] Includes planned 10-bed reduction, not part of title XIX adjustment.
[2] To be advanced to June 15, 1970, if emergency board allocates funds.
[3] 311 licensed as of Jan. 30, 1970.

EXHIBIT N

OREGON MENTAL HEALTH DIVISION

Memorandum to: Mr. Robert G. Davis, Assistant to the Governor, Human Resources; Mr. Andrew F. Juras, Administrator, Public Welfare Division; Mr. Ross Morgan, Administrator, Employment Division; and Mr. J. N. Peet, Administrator, Vocational Rehabilitation Division.
From: Kenneth D. Gaver, M.D., Administrator.
Subject: 1971–73 Community Program for the Mentally Retarded

The Mental Health Division must immediately establish program direction for the care of the mentally retarded for the 1971–73 biennium. The urgency is the result of the requirement to have preliminary capital construction items forwarded to the Department of General Services by February 20, 1970.

A decision must be made at once as to whether to develop an expanded capital construction program to care for the mentally retarded or to develop a community program for the retarded which will provide services out of hospital.

The Mental Health Division hospitals for the mentally retarded have undergone significant bed reductions this biennium. Displaced by the fire at Byrd Cottage were 189 patients; 68 beds will be restored on about May 1, 1970. After various transfers, 88 patients will still be residing at Oregon State Hospital. We believe that a building program to provide space for these patients must be developed.

In addition, approximately 160 beds will be reduced out of the total hospital capacity as the result of conversion to licensed nursing homes. This leaves the Division with a deficit in capacity somewhere in the neighborhood of 250 beds. A decision must be made whether to build for the entirety of that population or to develop community-based programs to care for patients out of hospital.

The Mental Health Division personnel concerned believe that the thrust and direction of the program for the mentally retarded should emphasize the development of additional community resources with only minimal addition of space at Fairview Hospital and Training Center to accommodate those Byrd Cottage patients now displaced to Oregon State Hospital. It is anticipated that approximately three cottages of 24 beds each modeled on the MacLaren cottage plan should be constructed. Preliminary cost estimates would indicate that this will be in the neighborhood of $600,000 to $750,000.

It is hoped to avoid the expenditure for capital construction purposes and expensive operation of the additional 170 beds by developing a strong community program, which will make maximum use of the resources and capabilities of all the Human Resources agencies. It is because of the need to establish this policy direction that I am writing you.

The Division staff believes that a broad, community-based program for the mentally retarded should include the following elements:

1. Contract for diagnostic and evaluation services with the Child Development Centers operated in five county health departments. This can be accomplished under the authority of chapter 253, Oregon Laws 1969 (Enrolled House Bill 1217).

2. Expand the program for the trainable mentally retarded under House Bill 1217 from its present age limits of 4 to 21 years to age limits 2 to 21 years and expand the number of children from the present 483 to come as close as possible to the anticipated population at risk of 1,900 such persons.

3. Expand the placement under the aegis of the Public Welfare Division of appropriate mentally retarded in community facilities, including:
   (a) Community-operated nursing homes for the mentally retarded.
   (b) Homes for the aged.
   (c) Foster homes for appropriate children.

4. Expand the availability of sheltered workshops for whom matching funds for construction and staffing must be made available from the Vocational Rehabilitation Division.

5. Transfer between 20 and 30 maximum disturbed mentally retarded to a new psychiatric security unit for which capital construction funds will be sought for Oregon State Hospital.

6. Develop three or more new halfway houses which potentially could be funded under the community mental health grant-in-aid program provided that the Vocational Rehabilitation Division and the Public Welfare Division have funds available to provide for client services and subsistence allowances.

It should be noted that halfway houses now cannot be operated directly by the Mental Health Division because of the limitations of section 3, Article XIV of the Oregon Constitution. This will be noted hereafter.

7. Develop a precare-aftercare specialty staff operated by the Mental Health Division in conjunction with the Outpatient Department at Fairview Hospital and Training Center. This would assist Public Welfare, Vocational Rehabilitation, and other agencies to provide the specialized precare-aftercare services necessitated by community placements of sizeable numbers of the mentally retarded. It is anticipated that case work services would still be required from Public Welfare personnel but that these special persons with wide experience in mental retardation would be a distinct asset to the program. This would require considerable planning with the Public Welfare Division.

8. Develop counseling, guidance, and (possibly) homemaker services under the provisions of chapter 53, Oregon Laws 1969 (Enrolled House Bill 1193), which expands the services of the Outpatient Clinic at Fairview Hospital and Training Center. A further statutory change might be required to shift the responsibility for operation of this Outpatient Clinic to the Mental Health Division.

Ideally, the Mental Health Division should have authority to establish three to five short-term, regional, residential centers for the retarded strategically located about the state. If operated by the Mental Health Division, maximum utilization would be made of Federal grant-in-aids funds for construction under the provisions of Public Law 88-164 and staffing of such facilities under the provisions of Public Law 89-105. However, Article XIV of the Oregon Constitution Prohibits the operations of such facilities by the State of Oregon.

To provide such authority, one alternative would be to have a legislative measure introduced which would be referred to the people, as was done for correctional services under the provisions of chapter 580, Oregon Laws 1969 (Enrolled Senate Bill 347.)

Mental Health Division personnel believe that a community-based program for the mentally retarded will provide improved services for the retarded, will enable a larger number of them to maintain the highest possible level of independent existence outside hospital walls, and will, for a reasonable investment, provide the best long-term benefits as to costs and program for the State of Oregon.

The program direction cited above is recommended, and the Mental Health Division would like to initiate immediately long-range planning discussions with other related agencies. I shall be calling you to set up such planning operations at the earliest possible time.

The CHAIRMAN. Thank you, gentlemen.

I believe that we have some answers in mind that are similar to what you are suggesting here, and we will try to meet that problem.

Mr. SCHNIBBE. Senator, Dr. Leopold has a statement, also.

The CHAIRMAN. Yes; now, we try to study these statements, and we have a good staff that works with us to digest this and to try to advise us of the points that witnesses think are special points, and we try, each one of us, to study these. But we are trying to operate here on a 10-minute rule for each witness. You have taken 25 minutes here and I would urge the doctor to try to summarize his statement in about 3 minutes. Please understand that we would like to take the time to study everything that you are saying and to consider it in as relaxed an atmosphere as we can, but we have the President of the United States making public statements by the day, criticizing us that this bill has not been reported. So I hope you will keep our problem in mind and try to summarize your position in 3 minutes. We will print the entire statement in the record.

Dr. LEOPOLD. I will attempt to be very brief, Mr. Chairman. I begin with a discussion of the provisions of the Long amendment, with which you are thoroughly familiar. But basically——

The CHAIRMAN. Ordinarily, you see, I would want to hear you discuss that in great detail. [Laughter.]

Dr. LEOPOLD. The requirement for individual patient planning, periodic review, alternative care, maintenance of effort, now, we think that in Vermont these requirements have been met.

We feel that in most of the States they have been met, and the systematic care which is provided through the Social Security Act, as it is presently written, should not be destroyed by the amendments proposed in H.R. 17550.

By a system of care I mean improved care for the mentally ill in our institutions so that they are, in fact, treatment institutions rather than custodial.

Your committee has heard about "human warehouses," and many of our State hospitals were such places. They are no longer. Since the enactment of Public Law 89–97 in Vermont, our State appropriations for mental health have doubled. These are not inflationary increases.

Our staff in State-operated mental health programs has increased by 35 percent. Our staff in the State-aided community mental health programs have increased by almost 200 percent.

These are the capabilities for providing alternative care to continued institutional custodial care and the continuation of active institutional treatment programs.

I would like to call the committee's attention to a recent issue of Saturday Review with an article by one of your members. This is only one in a series of articles about the health crisis which have appeared in the national magazines recently.

The CHAIRMAN. Who was the author of the article?

Dr. LEOPOLD. Senator Ribicoff.

The CHAIRMAN. Yes.

Dr. LEOPOLD. In all of these articles, the lack of systematic approach to health care in this country has been repeated, emphasized, and underlined.

It is our contention, as Mr. Schnibbe and Dr. Gaver have addressed the committee, that the publicly operated and financed State mental health programs are the most systematic approach to health care in the United States; that these programs are not only the most systematic approach to care for the mentally ill and the mentally retarded, but that they are also the best buy in health care and, as compared to the costs and the entrepreneurial private care system, our costs are much lower and our results are comparable.

The amendments in H.R. 17550 which the committee is now considering would destroy this ability of the States to continue the programs of a systematic approach of care to the mentally ill and the mentally retarded in this country.

We can demonstrate throughout our country in the 54 States and territories various elements of a systematic care which we are providing. Some States have made much more progress than others.

If these amendments are placed in effect it will, in essence, be saying to our State governments, to our Governors, and to our legislatures, the Federal Government is cutting back on its interest in programs for the mentally ill and the mentally retarded. "We are returning the burden to you and we will allow you, if you so choose, to make these institutions again into the human warehouses that they were 3, 5, or 10 years ago."

We feel, the National Association of State Mental Health Program Directors, that this cannot be allowed to happen. We cannot allow the

Federal Government to lead us into a retrenchment in the care of the mentally ill and the mentally retarded in this country.

During the period of operation of Public Law 89-97, our small State of Vermont, with limited resources——

Mr. CHAIRMAN. Could I interrupt you for a moment, to express the concern that some of us feel I am very much in favor of anything that can be done for people in the mental health area. However, I am against States simply taking Federal money and using it as a windfall for State budgets.

In States where a good job is being done and where the money that we are providing for mental health is being, conscientiously, effectively, and efficiently spent, I think that I speak for a majority on this committee when I say that we would not want to cut that. We would want them to continue to have what they are receiving and, perhaps, give them more help.

What we are concerned about is areas where States are wasting money, spending it inefficiently or even using it as a windfall for State budgets. We have some doubts that we should continue to pay that much money to States under those circumstances.

I would be curious to know what your reaction is to areas where we find that the money is not being used the way we intended it to be used.

Dr. LEOPOLD. Senator, I think that it would be difficult to demonstrate in any of our States the fact that Federal money has supplanted State funds. In Vermont the situation is that our State appropriations since the advent of medicare and medicaid have doubled.

The CHAIRMAN. I did not make the statement that Vermont has done that either. You know, I did not say that. I did not say that Vermont has spent the money inefficiently.

But we do have reports to the effect that some of the expenditures have been very inefficient in some of the mental health programs and offhand my impression would be to say that there would be no cutback in a program where the money is being effectively spent.

Dr. LEOPOLD. Mr. Chairman, I believe that this is the intent of our testimony. We are aware that there are abuses. We feel that few of them in the total health care picture occur within the mental health programs but our contention is that the programs should not be cut back but that the administration of the programs should be improved through the mechanisms about which Dr. Gaver has testified, has recommended in his testimony that utilization review, that independent medical audit, that program audit, should be increased.

We feel that these not only can be increased in our mental health programs, but that they can be expanded and the effectiveness of them can be increased in the skilled nursing home programs which are beyond our control throughout the health care system; that the mechanisms which we have applied in operating our State mental health programs can be increased in the mental health program, and that they can be applied and their effectiveness demonstrated elsewhere rather than across the board cuts which will most seriously affect the care of the mentally ill and the mentally retarded.

Dr. GAVER. Mr. Chairman, may I comment on it very briefly? The availability of reimbursement under this program has made it possible for States to move ahead into areas that we have not been able to move ahead into before, far in excess of Federal funds.

The CHAIRMAN. Can you give me some indication of what you think the potential to rehabilitate mentally ill people is? In other words, what is the potential here as far as restoring people to useful lives or restoring people to gainful employment?

Dr. GAVER. In the aged we will not expect a large number of the aged mentally ill to be returned to useful employment.

The CHAIRMAN. Most of those you just hope to return to society?

Dr. GAVER. You hope to return them to a better way of life.

The CHAIRMAN. Yes, sir; what is the potential?

Dr. GAVER. I think it is excellent.

The CHAIRMAN. What percentage of the aged can be returned to society and to a better way of life?

Dr. GAVER. The aged mentally ill coming into our hospitals I would say 85, 90 percent can be gotten out of the hospital in a better way of life. Many of them can return to their families.

Dr. LEOPOLD. We can, in addition, Mr. Chairman, improve the care of these people in the hospital as well as rehabilitating them, and we must be concerned for their care in the mental hospitals as well as those who leave and go into alternative placements, returning to their own homes or intermediate care or skilled nursing care.

The CHAIRMAN. Now, the point has been made to me that, perhaps, we are working with the wrong age group with medicare. What is the potential with regard to younger people, let us say people between 30 and 40, to restore them to productivity?

Dr. GAVER. Mr. Chairman let me say that before I came back into public administration I was in private practice in psychiatry, and in both instances working with the adult mentally ill, and I can say that the vast majority are gotten through their illness to a point where they can become—they can return to being self-supporting.

Mr. CHAIRMAN. When you say the vast majority, would you try to pick a percentage?

Dr. GAVER. Studies of a conservative nature have consistently shown 70, 75 percent and higher, depending upon your selection and that is assuming that these people in many instances did not have an opportunity for treatment early because of the cost involved in the care of these people, because of the lack of availability of the services, so we got them late, and still get a return to gainful employment and self-sufficiency.

The CHAIRMAN. Suppose we had $1 billion that we could allot you right now for care of the mentally ill, what would you think would be the best way to invest that money for the good of the people and for the good of society?

Dr. GAVER. Mr. Chairman, off the top of the head answer to that kind of question is a little bit difficult.

The CHAIRMAN. You are in that business, though, you ought to know the answer better than I would.

Dr. GAVER. Sir, I think an investment in early treatment and early rehabilitation of the mentally ill at any age would be a worthwhile investment.

The CHAIRMAN. You think if you had to choose between them you would probably say it is a more efficient investment and has greater potential if you start with the early age group than the later age group.

Dr. Gaver. Precisely, Senator.

Besides, starting out with the younger persons will restore people to society to work who can continue to be self-supporting and taxpayers.

The Chairman. So that is just one more example of where a person could be a taxpayer rather than a taxeater if we started out soon enough and made the investment to help restore that person to better health.

Dr. Gaver. Absolutely.

The Chairman. What you are complaining about here, and I agree with you, is that if we are going to have a program for the aged, that it is unfair and unjust to discriminate against people merely because they happen to be mentally ill.

Dr. Gaver. That is right. We have always maintained that position, Senator, but it seems to have had little impact so far. We have hopes that in the future Congress will see its way clear to change its opinion on that matter.

The Chairman. Well, you may be aware of the fact that I once kept Congress, at least the Senate, in session for about 4 days running just because I objected to that kind of discrimination——

Dr. Gaver. Yes, sir.

The Chairman. In our welfare program.

It just does not seem right to me that we would regard virtually everything else as being an illness except mental illness.

Don't we many times diagnose a person as being mentally ill when he is simply suffering from a condition that exists all over his body, hardening of the arteries, for example; doesn't that impair the ability of the brain to function effectively, as it does most of his organs?

Dr. Gaver. Senator, you are right. Many of the aged are suffering from a number and variety of ills, including arterial sclerosis, congenital heart failure including the degenerative process that catches up with people at some point in life.

A large number of them also are suffering from the fact that the conditions of life are so difficult that it is hard for them to cope with it. So you have physical and personal conditions with which they have to cope.

We also have aged schizophrenic individuals, whatever schizophrenia is, in my opinion, which is a basic metabolic disease.

The Chairman. Undoubtedly we are putting a lot or additional money into care for mentally ill people as a result of these Government health programs and most of that is directed to the aged, I take it. Is that right or wrong?

Dr. Gaver. That is precisely correct. Most of the money of the Federal Government today going into health care for the mentally ill goes to the aged mentally ill.

The Chairman. When we started out with the medicare program those who were advocating it selected the aged as those toward whom they wished to direct the program first because those people had very high medical expenses.

Actually, if you were approaching the problem of mental illness, would it not be fair to say that you would probably want to, start out by one that strikes at the disease across the board or one that starts with the younger people first?

Dr. GAVER. Senator, if we had our choice, and I am speaking personally now, we would start with children, because there are, for example, in the State of Oregon, 770,000 children between the ages of birth and age 18. Twelve thousand preschoolers, and 38,000 children of school age are in the need of mental health services.

To my knowledge, no Federal money is available today.

Mr. SCHNIBBE. Not much.

Dr. GAVER. Very, very small amount. But essentially for all practical purposes, Federal money is not available to this group.

The CHAIRMAN. At the time I was fighting against the Senate taking a calloused attitude toward mental illness, taking the view that mental illness is one thing and other illnesses are something else, the figures I read in the record at that time indicated that in a great number of the States people who are mentally ill were receiving little more than custodial care. In effect, I am saying about all we were doing is locking them up as we would a prisoner in a State penitentiary.

Have we gotten beyond that in most States or is that still a prevailing condition in many places?

Dr. LEOPOLD. Senator, I would like to answer that by referring to one of the provisions of this section 1902(a)(21). If the State plan includes medical assistance in behalf of individuals 65 years or older, the State must show that they are making satisfactory progress toward developing and implementing a comprehensive mental health program, including provisions for utilization of community mental health centers. This is an extremely important provision of the law as far as we are concerned, this association, and the individual State mental health program directors.

By securing medicare and medicaid funds we obligate ourselves to comply with this requirement and this gives us the opportunity to address our State governments and our State legislatures and say, "Yes, we are improving the care of the mentally ill aged with these medicare-medicaid funds but we must also comply with section 21 which requires progress toward a comprehensive mental health program throughout the State."

It is this, which is one of the major reasons why with the relatively small amount of medicare-medicaid money in our total budget, we have been able to make satisfactory progress and are continuing to make progress.

This, I think, is one of the most important parts of our testimony, that if there is a Federal cutback in the medicare-medicaid benefits, that it will not only affect the aged patients but the State legislatures can say to us, "Well, they have cut back on that and we don't have to comply with this requirement for satisfactory progress in developing and implementing a comprehensive mental health program."

The CHAIRMAN. You are here doing your best to help the kind of people that you treat and care for. I am curious to know why your group did not come in here and suggest to us some amendment that we might add to this bill that would certainly attract the support of those of us who recognize mental illness as being the most neglected aspect of health in this country—an amendment to make a substantial step forward in this area.

If you are asking for us to do something, effectively for the future, do you have in mind what you would suggest?

Dr. GAVER. Mr. Chairman, we have consistently advocated the position that payment for medical services——

The CHAIRMAN. Pardon me just a second. I believe you people came and asked us for legislation to study the feasibility of providing care for people under 65 in terms of mental illness, and that we enacted it. I think I helped to put it through.

Do you know anything about that report?

Mr. SCHNIBBE. I thought you got that report, Senator. It is my impression that HEW had completed it—I know they completed it. Our consultants had a draft of the report. Whether or not HEW submitted it up here to the Senate I do not know, but that should have been up here about a year ago.

That report did recommend that persons under 65 be covered in public institutions for mental diseases.

Right now under the law, payment can be made for a patient treated in a psychiatric section of a general hospital if he is, say 42 years old and is in a categorically related position or in one of the welfare categories. The discriminatory provision of the Social Security Act in title 19, to which we have objected, says that the same 42-year-old person cannot be treated in one of the hospitals run by Dr. Gaver or Dr. Leopold or the other 52 commissioners; that is, a person under 65 years of age who is a welfare recipient is discriminated against. These are the very persons for whom you have worked so hard over the last 15 years.

I might add, by the way, Senator, that all of our people are very much aware of the contributions you have made in this field, and as a matter of fact, you know there is a tendency within our ranks not to really make much of an effort on these issues before the House because we always figure with Senator Long in the Senate that is where we have our greater strength, and we make our fight for the mentally ill in the Senate.

The CHAIRMAN. I would urge you to do what you can to educate the House on this. [Laughter.]

Mr. SCHNIBBE. Well, that is true. We have to put more effort there. But in regard to persons under 65, we had brought this before your committee, and you had enough foresight to ask that a report be made by HEW on this issue, and if you do not have it we will help you to try and get it. Of course, we do not have great influence with HEW, but we can needle them a little bit. We have ways of persuading them to do things and we will make sure that that report gets to you somehow or other.

I am speaking for the two doctors, here, I do not know whether we can do this, but we will try.

The CHAIRMAN. The thing that most concerned me about all of this is that the area that you are testifying about, is the greatest area of human neglect that exists in this country, so far as I know.

When I began to look into this matter and tried to determine why it was that they did not include under our public welfare programs as beneficiaries people who were in mental institutions and people who are in tuberculosis hospitals, I learned that historically the view which had been taken was that these people were incurable and,

therefore, the best thing to do was to separate them from society and forget about them.

So when we tried to do something about it, we found that we were told that the cost would be very great, that the situation was hopeless, or that it was just something that the Federal Government should not even try to get into because it would be more than we could hope to care for.

Now, Senator Anderson was the initial sponsor and driver to try to enact medicare. I think it is a great tribute to Senator Anderson, the fight he made throughout the years to provide health insurance for aged people in this country.

One of the arguments I was making at the time when I was not supporting Senator Anderson's amendment, prior to the time it became a law, was that there were a lot of people who could afford to pay for a great deal of the medical care that would be provided under his health insurance approach, and that the money could, perhaps, better be used somewhere else. But in the area that your group speaks for, we had a situation, and I fear that in some cases it might still be going on, where people were not being treated; they were just being locked up the way you would lock up prisoners or animals, just to separate them from society when treatment could have restored them to society as a productive member or at least restore them to a happy life where they could find some degree of serenity between now and the time God calls them home.

Mr. SCHNIBBE. Senator, if this were not so tragic an impression it would be laughable, because this is no longer true around the country, generally speaking.

I suppose if you and I jumped on a plane and flew to two areas, we could find wards in certain hospitals where the care is not the greatest. But, generally speaking, if you had 50 State commissioners sitting here with you, they would all talk to you about the progressive programs of emptying the hospitals, and the new types of care that are provided in the hospitals and this is Arkansas, and this is Florida, and this is Montana, and it is New York and Massachusetts, and all of them.

The notion that the States as a whole are still operating custodial facilities is falacious.

Now, it still persists in places. Both of these doctors here today would probably say they know of a couple of instances around the country where it is still true.

The point is that right now this is generally a falacious notion. However, it is very hard to knock down. It is hard to knock down in the administration, whether it is a Democratic administration or a Republican administration, the notion still persists as you have well found out in your efforts to provide coverage for the mentally ill under public assistance laws, the notion persists that no care is given to these people, that they are put in so-called back wards and not treated.

I won't speak for Oregon or Vermont, because both of these doctors can, but I can tell you that the other 48 States, if they were sitting here, they would be itching to get to the microphone and say, "That is not true in our State."

It might have been true 30, 40, 50 years ago. It is not true today because some of the finest, most progressive, most exciting mental hospitals are State-operated programs in Little Rock, Ark., and Denver, Colo., and other State facilities all over the country.

The CHAIRMAN. Well, I believe that I was the one who successfully obtained matching for medicaid; so that should have at least doubled, I should think, the amount of money available to help people who were in these mental institutions——

Mr. SCHNIBBE. You did.

The CHAIRMAN. Can you obtain all the help you need to provide treatment for the people who are presently in these mental institutions? Not just provide custodial care, but treatment for these people who are in these mental institutions, if you had the money, could you provide all the active care necessary?

Dr. GAVER. Yes.

Dr. LEOPOLD. Senator, you are speaking of staff help?

The CHAIRMAN. Doctors, nurses,

Dr. LEOPOLD. Physicians, nurses, technician aides.

The CHAIRMAN. Right.

Dr. LEOPOLD. Yes, sir.

In the 4 years in which we have been operating the medicare-medicaid program in the State of Vermont, our mental hospital population has decreased from 1,590 to just under 1,100 this month, and I am not sure just what the exact figure is, something around 1,080 or 1,090. That is a decrease of approximately 35 percent in this 4-year period.

During the same period of time our aged population has decreased by about 25 percent. We have not been as successful as the figures that Dr. Gaver cited for Oregon and for Missouri where their aged population in mental hospitals has decreased from 45 to 48 percent.

During this same period of time in all of the States the number of the patients admitted to mental hospitals has approximately doubled so that where we in Vermont had in 1965 600 admissions a year, we now have 1,200 admissions a year.

We are accomplishing this increased workload with an increased staff.

Yes, the trained staff is available to us, and we have been successful during these past 5 years especially of recruiting more and more professionally and technically trained individuals into publicly operated mental health programs and turning the tide that Mr. Schnibbe referred to from custodial care to active and intensive treatment.

I think that in many, if not all, of our States, we can show records of effectiveness which are comparable if not better than that care which is obtainable in the private sector at far greater costs.

Dr. GAVER. Mr. Chairman, I provided the committee with some representative graphs. These happen to apply to Oregon, exhibit A, the very first exhibit, which illustrates, for example, the decline of the total population in Oregon hospitals. Incidentally, that little upturn of the line there should be a downturn. That was a projection made a couple of years ago. We are still going down.

On top of that we are taking in more——

The CHAIRMAN. You say the total population is decreasing. Is that because you are discharging people who are capable of being discharged?

Dr. GAVER. Yes, sir. It is because we are discharging people who are capable of being discharged because——

The CHAIRMAN. Those people are being treated and being returned to society, I take it?

Dr. GAVER. Treatment techniques are better than they were.

The CHAIRMAN. Yes.

Dr. GAVER. This illustrates the rising intake. This happens to illustrate the decline in the aged.

The CHAIRMAN. Wait just a minute. Let me find the chart you are looking at. That would be exhibit B.

Dr. GAVER. This happens to be the aged, dropping the aged population, exhibit C. It is down in the lower right-hand corner where it says exhibit C. (See p. 516.)

The CHAIRMAN. I see.

Now, you say State and mental hospitals, is that all?

Dr. GAVER. No, sir; I'm using all the illustrations from the State of Oregon, but I can guarantee you that comparable charts could be drawn for virtually every State.

Mr. SCHNIBBE. That is only in Oregon.

The CHAIRMAN. So that the number—what does this code mean, DSH?

Dr. GAVER. That is simply Dammasch State hospital. The others are Salem and Oregon State Hospital. There are three mental hospitals.

The CHAIRMAN. So those are the resident patients in those hospitals, and you are making great progress in reducing the number. Are those aged people you are speaking of or are they all patients?

Dr. GAVER. This exhibit, C is aged. But if you go back two exhibits, to exhibit A, this is all patients, and the line is still going down. This dotted line was done by my research analyst some time past. He was on vacation and I could not have him update it.

The CHAIRMAN. I see.

Mr. SCHNIBBE. Senator, you understand these are resident patients.

As Dr. Leopold said, the admissions are doubled while the resident patients are radically declining. This means the hospitals are doing more and more and more work and people are moving in and out faster and faster all the time.

Dr. GAVER. And, Senator, our admission rate is not rising because of readmissions; it is our new admission rate that is rising. Every patient who comes in gets a physical examination; he gets a psychiatric examination; he is seen by a social worker; his family is interviewed. He receives, if needed, tranquilizer; and if indicated an antidepressant drug; he receives occupational or recreational or other therapy.

When he goes out, is ready to leave any of our hospitals, in Oregon today, arrangements are made for after care if he needs it.

For example, at Dammasch State Hospital, serving the Metropolitan Portland area, this is a 457-bed hospital. We have four patients in each bed every year; in other words, we turn over the population in that hospital four times a year, and everybody in that hospital goes out to an after-care program operated by the community program. He goes back to work but he comes in and gets medication if needed or he comes in and gets into a group psychotherapy situation or whatever may be appropriate, and this is the kind of thing you are seeing all over the country.

The CHAIRMAN. Do you actually think that is typical of the progress that is being made in the Nation?

Mr. SCHNIBBE. Yes, sir; it is, all over.

The CHAIRMAN. It would seem to me if we are getting that much return on our money we ought to put more into it and see if we cannot reap a greater profit. That sounds like a very great investment.

Mr. SCHNIBBE. We would like to have you chairman of the Appropriations Committee when you talk like that.

The CHAIRMAN. Well, fortunately, this is the only committee that can authorize and appropriate money.

Mr. SCHNIBBE. That is true.

The CHAIRMAN. There was a time in the history of this country when this committee was both the Finance Committee and the Appropriations Committee; however, at the time of the Civil War the Government expenditure became so great that they needed a separate committee to handle appropriations.

Mr. SCHNIBBE. That is still true of these funds, though. They are in a sense open ended, the medicare funds, so I guess we are dealing with the right committee.

The CHAIRMAN. Gentlemen, as I understand it, you came here to protest discrimination against the mentally ill in this bill. You think a lot more could be done for the mentally ill particularly those who are under the age of 65.

Dr. LEOPOLD. Yes, sir. The Long amendment was very farsighted in the variety of approaches and requirements for cooperation, for program planning, for individual planning, for progress in program and programs. But it was restricted solely to the old age assistance recipients and, as you know, Senator, there are many, many persons under the age of 65 who are presently disabled who fit into the aid to the permanently and totally disabled category who would also substantially benefit from such an improvement in program as well as many, needy children.

One of the trends—it is not a trend, it is a very apparent change—is the increased number of children who are admitted to our State mental health programs, not only to our mental hospitals but to our institutions for the mentally retarded, and a rapidly increasing demand for services to children in our community mental health programs.

The CHAIRMAN. Thank you.

(The prepared statement of Dr. Leopold follows:)

STATEMENT OF JONATHAN P. A. LEOPOLD, M.D., VERMONT COMMISSIONER OF MENTAL HEALTH FOR THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

My testimony will be directed at understanding present programs for the care of the mentally disabled, particularly as they have developed since the passage of P.L. 89–97 and especially as state mental health programs and P.L. 89–97 have affected the care of the mentally ill aged in our population.

The sudies of the Joint Commission on Mental Illness established by the Congress in 1956 were published in a report titled "Action for Mental Health; Final Report of the Joint Commission on Mental Illness and Health" and reported to the Congress in 1961. This report as well as subsequent findings by your committee and your continuing interest led to enactment of the Medicare-Medicaid legislation including the "Long Amendment" directed at improving the care of mentally ill aged persons in our society. State hospitals have been characterized as "human warehouses"; the provisions of Section 1902.(a) (20) (21) are a comprehensive and systematic attack program on the care of the mentally ill aged in the United States:

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

(A) provide for having in effect such agreements or other arrange-

ments with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions were needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

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

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

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

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

They provide for coordination between the state welfare agency and the state mental health agency. They provide for individual planning and periodic review of the plan and program for each patient. They provide for alternative care and they provide for reasonable reimbursement of the costs of such care and treatment. In addition, and of at least equal importance is the requirement that the state make "satisfactory progress toward developing and implementing a comprehensive mental health program". I believe it is possible for our states, and for many if not all of the participating states, to show such progress in care of individual aged patients, suitable alternative care as well as successful efforts toward development and implementation of a comprehensive mental health program.

The changes proposed in H.R. 17550 will reverse these progressive trends and have a serious, negative and destructive effect on the care of these patients and on the progress of comprehensive mental health programs in our states.

In enacting P.L. 89–97, the Congress stated its intention:

> To provide a hospital insurance program for the aged under the Social Security Act with a supplementary medical 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.

In addition to the above statement, the Congress made a further declaration of findings and purpose in enacting P.L. 89–749:

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2(a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshaling of all health resources—national, State, and local—to assure comprehensive health services of high quality

for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.

(b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.

The provisions of H.R. 17550 will interfere and impede the progress of the states and the nation in achieving these clear objectives. They seem to be directed at the reduction of program costs to the federal government; this is a laudible goal and consistent with the public interest. The operational effect of these amendments, however, would be destructive toward the development of the comprehensive mental health programs and destructive to the care of the individual mentally ill person.

PROGRAM PROGRESS SINCE IMPLEMENTATION OF P.L. 89–97

Vermont is a small state with a dispersed population and limited resources. It has, since 1965, made considerable progress in its mental health program specifically:

(1) Our dollar expenditures in mental health programs have more than doubled, far exceeding the maintenance of effort provision of P.L. 89–97.

(2) The number of staff persons engaged in our mental health programs have almost doubled. The number of volunteers has more than doubled.

(3) During the same period of time, our caseload, that is the number of persons in active treatment, have shown an almost comparable increase and the workload, that is the numbers of patients admitted for inpatient, outpatient and aftercare have also similarly increased. However, during this period of time the number of patients in 24-hour mental health institution care has decreased; the number of aged patients in our major mental institutions has decreased and the number of aged mentally ill patients chargeable to Title XIX has decreased as follows: In Fiscal 1967 the number of patient days billed to Medicaid was 120,105. In 1969, 113,728 and it is estimated that in 1971 there will be a decrease to 97,455. The average number of Medicaid patients in our mental institutions in Vermont during these same three years has decreased from 329 in 1967 to 303 in 1969 to an estimated 267 in 1971, a decrease of 8% from 1967 to 1969, and 12% from 1969 to 1971.

	Total
Number of days billed to title XIX in years:	
1967	120,105
1969	112,728
Estimated 1971	97,455
Number of patients on title XIX in years:	
1967	329
1969	303
Estimated 1971	267

I believe these figures demonstrate not only our "good intentions" but, more importantly, the effectiveness of our programs. We have attempted to comply with the provisions of Title XIX and it is obvious that we have succeeded.

I have included in my testimony ten randomly-selected case histories of patients who are currently receiving or have received Medicaid benefits during their hospitalization in Vermont State Hospital. They show the variety of types of recipients. They show the variety of types of outcome and I believe, by implication, they show the continuing need for such care.

EFFECTS ON STATE MENTAL HEALTH PROGRAMS AND ON INDIVIDUAL RECIPIENTS OF H.R. 17550

It is possible to predict within reasonable accuracy some of the effects of H.R. 17550:

(1) A decrease in benefits as proposed would have the adverse effect of causing nursing homes to return aged mentally ill persons from their care to the care of the state hospitals, the traditional dumping ground for society's rejects, returning such institutions to their previous status of "human warehouses".

(2) Enactment of H.R. 17550 would have an adverse effect on our state legisla-

tures as they regard our state mental health program. It would say to them, "The Federal government no longer cares about our mentally ill and it wishes to shift more of the burden back on us at a time when increasing demands for human and environmental preservation and protective services are placed upon us." It would set a deplorable example of decreasing social concern for the aged and the mentally ill. It would inevitably cause a loss of impetus for progress and consequent slow-down. On the positive side, I would call to your attention that our state mental health programs are a *systems approach* to the problem of comprehensive health care (in the mental health sector); that controls or potential controls on state mental health systems exists and that with continued interest and assistance by the federal government that the administration of this program can become even more effective than it presently is. We have been successfully able, as I have previously mentioned, to change emphasis of our program away from 24-hour (mental) institution care to a variety of types of community care. At the present time, approximately four-fifths of the total expenditure for psychiatric or mental health services to individuals in each of our states is directed and controlled or supervised by our state mental health programs. The cost of care in such programs is far less than it is in the non-public sector for the care and treatment which, in many cases, is no more effective in measurable outcome than that provided by public sector programs. In short, public mental health programs are the *best buy* at the present time in the entire spectrum of health care services. A decrease in federal participation at this time can only have an adverse affect on the continuing development and effectiveness of these "best buy" programs.

What things can be done to further improve care and still keep costs within reasonable limits? Requirements for periodic review, utilization and alternative care must be extended to nursing home care through more effective utilization review and through further development of intermediate care facilities and community living situations for dependent disabled persons. Standards for the development of such alternative facilities should be developed with a view toward capitalization costs which the nation and the states can realistically afford. They must also, however, be developed with reasonable professional support systems which will ensure their effective operation while meeting the needs of the people served. By this, I mean consultative services of health professionals to ensure not only adequate medical care but care which will emphasize prevention of social and medical disability and dependency which would necessitate re-admission to a treatment facility. We have numerous examples in various parts of our county of such programs demonstrating their effectiveness. Such programs must receive encouragement and support from the federal government.

In summary the proposed amendments in H.R. 17550 represent increased discrimination against the aged and mentally disabled in our population. They will have the effect of decreasing rather than increasing the federal partnership with the states in improving the care of the mentally ill. They will penalize the more controlled and promising aspect of the health care system in this country, i.e., the state directed mental health programs, and they fail except by negative financial limitations to get to the heart of the nationwide increase in costs in the entrepreneurial private and voluntary sector.

CASE SUMMARIES, SEPTEMBER 8, 1970

Miss L.A. Residence: Georgia, Vt. DOB: October 3, 1894. Date Admitted: March 27, 1929. Diagnosis: Schizophrenic, Paranoid type. Marital Status: Single.

Miss A was admitted to the Hospital on March 27, 1929 at the age of 34 years. She was the third child in a family of four children. As a young girl, she was described as being somewhat seclusive and quite sensitive. Miss A graduated from high school at the age of 18, after which she worked in the office of the town newspaper. She continued her education at the Vermont Business College and graduated after one year.

Her problems became apparent seven years prior to admission. She began hearing voices and felt that people could read her mind and, thereby, influenced her behavior. She was wandering around aimlessly, attempting to borrow money from strangers on the street and threatened to do injury to those who refused.

Miss A has spent 41 years at the Hospital and is presently 75 years old. Her condition has remained throughout the years somewhat the same. She could

best be described as a "burnt out schizophrenic" who has become institutionalized and completely separated from family, friends and community. Our present treatment program is aimed at combating this institutionalization, now that her mental illness has achieved some stability. A change in medication has caused a noticeable effect. She is in a re-socialization group for the purpose of reintegrating her back into society. It is hoped that after several months, she will be able to leave the Hospital to live in a supervised family care facility.

(Paul Blake/Social Worker/seh).

R.B.—female. Residence: St. Albans, Vt. DOB: June 3, 1904. Date of Admission: May 2, 1964. Diagnosis: Schizophrenia, paranoid type. Marital Status: Married.

Mrs. B was admitted to Vermont State Hospital as an involuntary patient on a probate court order. She had previously been hospitalized from 7/29/61 to 11/2/63. She lived with her husband, 10 years older than herself, who is not in good health. She has four married children who live in Vermont. Mrs. B was readmitted to Vermont State Hospital because of a recurrence of her suspicious, tantrums, loss of memory and disruptive behavior consistent with her illness.

While at Vermont State Hospital, she was enrolled in the Vocational Rehabilitation Program. This was discontinued because of a lack of motivation on the part of the patient.

Mrs. B is currently residing on an open geriatric service. She is quiet, cooperative and able to attend to her personal needs. In general, the patient is uninterested in any activities and although she has ground privileges, does not go outside unless urged to do so by staff. Her physical health is fairly good, the major problem being obesity. The patient is on a special diet. Current medications are: Mellaril 25 mg TID, Tofranil 50 mg TID, Kemadrin 5 mg BID.

Mrs. B. is being considered for alternative placement in a boarding home under hospital supervision. Her family is unable to provide a living situation with the necessary supervision and guidance which the patient requires. She received Medicare and Medicaid benefits during the course of hospitalization.

(Marilyn Wallace/Social Worker/seh).

M.J.M.—male. Residence: Bennington, Vt. DOB: November 17, 1893. Date of Admission: 7/17/69. Diagnosis: Alcoholism, alcohol addiction. Marital Status: Separated.

Mr. M came to Vermont State Hospital on a voluntary basis for treatment of his alcohol problem. Prior to his admission, he had been living alone and drinking regularly. While at the Hospital, he attended the alcohol program meetings. His slight depression improved and he was assisted in finding living quarters at a nearby rest home for the aged.

This admission was his first to this facility. In view of the fact that he has been living in a custodial environment for the past year, the prognosis appears good.

While at Vermont State Hospital, Mr. M was covered by Medicaid, not Medicare.

(Marilyn Wallace/Social Worker/seh).

C.E.C.—female. Residence: Waterbury, Vt. DOB: July 30, 1879. Date of Admission: August 8, 1969. Diagnosis: Psychosis Associated with Arteriosclerosis. Marital Status: Widow.

For six years prior to admission, this patient had been in a nursing home in the Village of Waterbury. Immediately prior to her admission, she had fallen in the nursing home and had been taken to a general hospital for treatment. During her hospital course, she became quite unmanageable, disorganized and disoriented. In addition, there were no injuries found resulting from her fall: subsequently, she was returned to the nursing home but continued to be noisy, resistive, disoriented, disturbing to other patients, and a general management problem. Consequently, she was admitted to the State Hospital in August of 1969. She had received Old Age Assistance prior to her admission to the State

Hospital and initially received Medicare benefits for the first period of her hospital stay. After these benefits were exhausted, she was placed on the Medicaid program. She was admitted to the Medical Surgical Service and it was the opinion of staff that she was in good physical condition for a 90-year-old. She required medication at night to prevent her from crawling out of her bed; after several months of hospitalization, her physical condition improved and she was able to be up and about the ward. She continues to be confused and disoriented, has a tendency to wander, is incontinent, and in general is a total nursing care patient. It is the opinion of the staff at the Hospital at this time that it would not be feasible to consider placement in a nursing home and it is expected that she will remain at the Hospital until her death.

(Paul Brodeur/Chief of Social Services/jj).

H.T.—female. Residence: Northfield, Vt. DOB: July 9, 1889. Date of Admission: June 12, 1947. Diagnosis: Involutional Melancholia. Marital Status: Married.

This patient was admitted for the second time to the Vermont State Hospital in June of 1947 from a general hospital in Montpelier. She had had a previous admission to the State Hospital from March of 1946 until October of 1946 with a diagnosis of involutional melancholia. She had been discharged as improved. Two-and-one-half years prior to the first admission, she had become increasingly depressed and obsessed with the idea that she had syphilis. She was taken to a local hospital where it was recommended that she be admitted to the State Hospital. Following her discharge, she returned to her husband's home but continued to be depressed and increasingly concerned with a variety of somatic complaints. This led to her re-admission. In 1948, she received a series of 17 ECT treatments which produced some improvements in her status. However, she was plagued for a long time with chronic diarrhea and colitis. She went on conditional release to her home from July of 1949 to April of 1950, but had delusions and obsessions to the point that her husband was unable to manage her. This patient has had a history of a variety of physical problems including gallstones, hypertension and generalized arteriosclerosis. She was placed on the Medical Surgical Service in 1962 and remained there until 1967, when she was transferred to another ward. She continued to receive nursing care and treatment but was never considered for placement back into the community. She had received benefits under the Title XIX program since it started at the Hospital but periodic reviews done by hospital staff found her rehabilitation potential poor. Although over the past two years discussions had been held with the patient regarding possible nursing home placement, she expressed an active reluctance to go. In June of 1970, she was transferred to the Medical Surgical Service because of her slow downhill course and vomiting. She was showing a weight loss and on July 15, 1970, she died. Cause of death was listed as bronchial pneumonia, arteriosclerotic heart disease and secondary anemia.

(Paul Brodeur/Chief of Social Services/jj).

L.C.L.—female. Residence: Enosburg, Vt. DOB: May 24, 1903. Date of Admission: October 20, 1964.—Diagnosis: Schizophrenia, paranoid type. Martial Status: Divorced.

This patient was admitted for the second time to the Vermont State Hospital in October of 1964. Prior to her admission, she had been living alone in an apartment in Enosburg, Vermont, and had increasingly become hostile, suspicious and beligerent. Just prior to admission, she had been lost in a wooded area in Enosburg over night and, apparently, this led authorities to take action to admit her. She had received teacher's training as a young adult, and for eighteen years worked in a post office and an express company in Enosburg. Following her admission, she was found to be cooperative but seclusive, delusional, and experiencing hallucinations and was placed on Trilafon and Kemardrin. She was placed in a social rehabilitation group in March of 1965, and reached the point where she was able to work in the Hospital. She continued to socialize very little, but was able to take part in remotivation programs and continue in her work program. In July of 1969, she began to exhibit spontaneous choreiform movement involving the lower limbs and the hands. Phenothiazines were discon-

tinued but these movements persisted. At this time, she had freedom of movement within the Hospital, continued in the remotivation program, and participated in ward activities. She was oriented to her surroundings and had a definite coordination problem. In November of 1969, she was transferred to another ward because of her inability to manage the walk to the dining area and the following month, the Social Service Department was able to locate a rest home for her where she was placed. At the time, she was receiving Cogentin 2 mg TID and Kemadrin 5 mg BID. A recent report from the rest home indicates that she continues to get along well and has presented no serious problems since her admission there. She receives Old Age Assistance from the Department of Social Welfare.

(Paul Brodeur/Chief of Social Services/jj).

Miss M.S.—female. Residence: Montpelier, Vt. DOB: 1898. Date of Admission: March 12, 1927.—Diagnosis: Schizophrenia, Catatonic type. Marital Status: Single.

Miss S was admitted to this Hospital on March 12, 1927 at the age of 29 years. She came from a family with a history of mental illness. She was the oldest of three children who were all described as quite healthy. Miss S graduated from high school and also business college, and worked as a secretary up to the time of her admission. Her problems began about three years prior to her admission. She broke an engagement to a young man, but began to brood over the fact that she may not have been quite fair to him. She became quite nervous and depressed and began thinking about suicide. She became unable to sleep and began to physically strike out at the people around her. Her hospital course has been marked by disturbed and aggressive behavior towards other patients. Miss S becomes irritated and will push and curse other patients, or her behavior becomes the opposite where she withdraws into herself and does not relate to anyone.

At the present time, Miss S is on a ward where she is receiving a great deal of supervision and care. The prognosis for her is extremely poor because processes of old age are beginning to show, mainly by increased confusion, memory loss, and the increased amount of nursing care needed.

(Paul Blake/Social Worker/seh).

G.G.—male. Residence: Holland, Vt. DOB: October 11, 1899. Date of Admission: February 26, 1930. Marital Status: Married.

This 70-year-old man was admitted to the Vermont State Hospital at the age of 30 after exhibiting mental depression, ruthlessness and nervousness. His wife and children irritated him and he was unable to attend to his work. On admission, he was quiet and cooperative to the point of apathy, showed no insight into his condition, and in fact denied there was any problem.

At first willing to perform some hospital tasks, gradually he refused to apply himself and would sit idle. He denies hallucinations, although inappropriate smiling and laughter cast doubt on his denial. Described as withdrawn and indifferent for the next 20 years, he would sit idle and hallucinated, mumbling to himself, disoriented.

Transferred to a Medical Ward in 1955 because of a chronic bowel problem, he continued much the same for many years. He picked up the compulsion of "washing" the wall with his hands. He would play with water and was occasionally irritated.

Transferred to a nursing home in March 1970, he did well for approximately five months until he began refusing his meals, masturbating in public, and even in front of guests, and disrupting the cleaning staff with his spitting on the floor and messing up the linen closets. Because of this behavior which appear to be increasing in intensity, he was returned to the Hospital in August 1970. Since his return, the staff has seen no re-occurrence of the masturbation, but have noticed a marked increase in his irritability and in his attempts to steal food between meals.

Should it appear appropriate in the future, nursing home placement will again be considered.

(Duncan Robb/Social Worker/seh).

E.W.M.—female. Residence: Bethel, Vt. DOB: April 16, 1904. Date of Admission: March 21, 1967. Diagnosis: Maine depressive illness, manic type. Martial Status: Widow.

Mrs. M was re-admitted to Vermont State Hospital when her behavior became too agitated for her sister, with whom she has lived since 1962. She was previously hospitalized from 7/17/64 to 6/24/65 with the same diagnosis. Just prior to the last admission, she was unable to sit still, laughed or sang all night, used abusive language and was careless with her cigarettes.

Mrs. M has improved slowly but continues to have periods of restlessness, over-activity and uncontrolled talking. She is interested in ward activities and is currently residing on an open geriatric ward. On various occasions, she has been carried on the Medical Ward for a cardiac condition and recently for pneumonia. Mrs. M particularly enjoys attending the Roman Catholic Church chapel services on a regular basis. Her sister visits about once a month.

Mrs. M is currently receiving these medications: Thorazine conc 50 mg BID, Resperpine 0.25 mg QID, Kemardin 0.5 mg TID, Lithum 300 mg BID, Artane 2 mg BID, Phenobarb 15 mg OD.

Mrs. M fluctuates from a cooperative, good-natured, interested person to an over-active, often aggressive, and noisy one. She will remain at the Vermont State Hospital until this condition is stabilized. In the future, she could possibly be considered for nursing home care.

(Marilyn Wallace/Social Worker/seh.)

Dr. GAVER. Senator, may I make one further comment?

The CHAIRMAN. Yes.

Dr. GAVER. It is peculiar to me that under medicaid care of certain patients under 65 years of age can be paid for in, for example, Salem Memorial Hospital, that hospital not having any psychiatric service. In the same town, a public mental hospital organized to provide special psychiatric treatment cannot receive payment for its service for that same patient. It is ridiculous.

The CHAIRMAN. Well, you know why we could not resolve that ridiculous anomaly, and that is because the administration at that time were greatly concerned about the cost if we simply proceeded directly to provide care for the mentally ill in mental hospitals.

So, to keep their costs down, they were willing to pay for some examination and some small amount of treatment in a general hospital, but not in a mental hospital.

Perhaps we can do something about that in this legislation. I hope so.

Mr. SCHNIBBE. Senator, it just occurred to me that about three-quarters of an hour ago we were supposed to have lunch with one of our other commissioners from Wisconsin who is presumably still waiting somewhere in the city for us. He was on the consultant task force for HEW that drafted the report which was to have been provided to you a year ago on recommendations of the treatment of persons under 65 years of age in public institutions for mental diseases or specialty institutions. If he has not given up on us, I think he is the person we will now confer with to make sure that that information gets over to you.

The CHAIRMAN. Right.

Mr. SCHNEBBE. At least I hope we can get it to you.*

The CHAIRMAN. Thank you, gentlemen.

Is there anything more you wish to add to this presentation?

Thank you very much for a very fine statement. I am pleased to know the headway that you are making. I think that speaks for the whole committee and I do believe that your statement points up that

*See volume 3 of these hearings for a subsequent letter of Mr. Schnibbe.

you should have come and asked for even more as far as the chairman is concerned.

Thank you very much, gentlemen. We will meet again at 10 tomorrow.

(The committee subsequently received the following letter from Mr. Leopold:)

STATE OF VERMONT,
DEPARTMENT OF HEALTH,
Montpelier, September 22, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: At the close of testimony presented by Dr. Kenneth Gaver, Harry Schnibbe and myself on H.R. 17550, you asked us a number of questions regarding program proposals put forth by our Association. On behalf of the National Association of State Mental Health Program Directors, Dr. Gaver and I wish to thank you and the committee members for your time, patience and consideration. We are exteremly pleased that your interest in the mentally disabled in our society continues.

In view of your committee's interest in, and insistence upon, more effective utilization review, independent medical audit and program audit, principles which we accept and fully endorse, we therefore wish to make some changes in our proposed amendments to H.R. 17550. These amendments, if adopted, would assure the program utilization control necessary to effective operation and achievement of the mandated goals of improving the care of our mentally disabled.

Amendment # I

H.R. 17550 is amended to *add* on page 105, line 3, following "year" the following: "in the same skilled nursing home" and further is amended to *add* on page 105, line 4 following "and" the following: "if the state is presently participating or in the future elects to participate under the provisions of section 1902a (20) that state shall provide in its state plan developed and implemented methods of assuring utilization review as imposed by section 1861 (k) for purposes of Title XVIII, independent medical audit, and program audit as approved by the Secretary. Failure to provide such review and audits shall subject that state to the provisions of section (C) until compliance with the review and audit requirements are effected.

This amendment, as proposed, would penalize the states for non-compliance, but would allow the continuation of the program in those states where the mental health authority and the individual institutions have operationally provided satisfactory compliance. Measurement of satisfactory compliance would of course be dependent upon sufficient staff in the HEW Regional Offices to adequately monitor and confirm compliance.

Amendment # II

H.R. 17550 is amended to *add* on page 104, line 21 following "thereof" the following: "and, if a skilled nursing home does not incorporate into its operational program methods of assuring utilization review as imposed by section 1861(k) for purposes of Title XVIII, independent medical audit and program audit as approved by the Secretary, such skilled nursing home shall be subject to the provisions of section (B) until compliance with review and audit requirements are affected.

This amendment would provide for compliance of skilled nursing homes on the basis of individual facilities, thus if one facility achieved compliance it would continue to receive eligible recipient patients without penalty either to the facility or to the individual recipient. It is our feeling that this method would not only be more equitable to recipients (presently provisions of H.R. 17550 penalizes recipients who have no contro lover the care systems which they enter, nor can they control or affect the compliance) but would also allow a state to continue to utilize those facilities which have attempted to comply rather than have a wholesale program reduction and penalty.

Amendment # III

On page 107 strike lines 7 through 11.

Amendment # III is the same as that which we proposed in our testimony, i.e., it would eliminate the exclusion of public institutions from intermediate care facility operation. We have previously commented on the desirability and necessity of continuing inclusion of public facilities in the intermediate care program.

Amendment # IV

In section 238 on page 133 of the bill, add the following language on line 21 following the word "agency"—", with the consultation and agreement of the mental health and mental retardation authority, in regard to program design and program quality,".

On page 134, line 4, after the word "health", add the following phrase "such as mental health and mental retardation,".

On page 134, line 18, after the word "health" insert "and mental health and mental retardation".

This amendment assumes importance from the viewpoint that mental health and mental retardation program standards must be established by the mental health/mental retardation authority rather than by the (public) health authority which, in many states, does not understand mental health/mental retardation program goals and methods. Cases of such misunderstanding in our states as well as by Medicare fiscal intermediaries are well documented, and on record with the staff of your committee.

In your questioning of Dr. Gaver, Mr. Schnibbe and myself you inquired about proposals for program involvement for care of mentally disabled persons under the provisions of Title XIX. At that time we stated that our Association was previously on record supporting the elimination of discrimination against persons under 65 years of age. I have enclosed a copy of the testimony of Leonard Ganser, M.D. of Wisconsin before your committee and before the House Ways and Means Committee during 1967.* These statements fully document the reasons for which we proposed the elimination of this discrimination.

I have also enclosed a presentation of "Financing the Care of the Mentally Ill under Medicare, Medicaid" by Dorothy P. Rice, Ruth I. Knee and Margaret Conwell. These people, along with several others, were members of the ad hoc committee which studied these questions during 1968. This paper was presented at the annual meeting of the American Public Health Association in Philadelphia November 13, 1969.**

On behalf of the Association, Dr. Gaver and myself, I wish to thank you again for your interest and attention.

Sincerely,

JONATHAN P. A. LEOPOLD, M.D.

(Thereupon, at 1:15 p.m., the committee adjourned to reconvene at 10 o'clock on Wednesday, September 16, 1970.)

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*See Committee on Finance hearings entitled "Social Security Amendments of 1967" pt. 3, pp. 1740 ff.

**The paper was made a part of the official files of the committee.

SOCIAL SECURITY AMENDMENTS OF 1970

WEDNESDAY, SEPTEMBER 16, 1970

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

The committee met, pursuant to recess, at 10:05 a.m., in Room 1221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Talmadge, Byrd Jr., of Virginia, Williams of Delware, Miller, and Jordan.

The CHAIRMAN. In view of the fact that the Senate is in session and Senator Percy will have to participate in the debate immediately, Senator Harrison Williams of New Jersey has generously consented to permit Senator Percy to open with his statement and then we will take Senator Williams.

Senator Percy.

STATEMENT OF HON. CHARLES H. PERCY, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Senator PERCY. I wish to extend my deep appreciation to my colleague, Senator Williams, and his guests.

Mr. Chairman and members of the committee, I welcome this opportunity to set forth my views on the social security program.

Our social security system is one of the most successful, effective programs ever devised by Congress. To assure its continued success, we need to reevaluate it periodically—as this committee is doing—and ask ourselves whether the program, in its growing complexity, has overlooked or failed to help certain individuals. Do our methods of fulfilling the original purposes of social security need to be modified in any way? Should these purposes themselves be changed?

I would like to talk on five particular areas where I feel we can improve and strengthen the social security system.

The first deals with benefits for unadopted grandchildren dependent upon their grandparents.

In raising the questions as to whether the program has failed to reach certain individuals it should help, I concluded that it has overlooked some individuals. Under the present social security law, some children who are dependent on their grandparents cannot obtain benefits based on their grandparents' earnings. A grandchild must be adopted by his grandparents before he qualifies for a child's social security benefits. This is most unfortunate, as there are cases in which the grandparents, for valid reasons, are either unable to do or do

not wish to adopt the child, yet still maintain a quasi-parental relationship.

The purpose of social security is to provide the family with a continuing source of income when the family income stops because of the death, retirement, or disability of a worker. Following this, social security benefits are paid to children whose parents have died, retired, or become disabled on the theory that children are generally dependent on their parents and suffer a loss of support when the parents' income stops. However, if that "parent" is a grandparent the child suffers in being denied a social security benefit. Benefits are extended to grandchildren only when they are legally adopted.

This distinction which prohibits the unadopted child living with and supported by his grandparents from receiving the same benefits he would receive if he were adopted is grossly unfair. A child dependent on his grandparents is as deserving of social security benefits as a child who is dependent on his parents—perhaps even more deserving as grandparents very possibly would have less income. The payment of these benefits should be based on the realities of the situation.

I therefore urge favorable action on my amendment to permit the payment of social security benefits to the dependent grandchildren of disabled, retired, or deceased workers when it can be shown that the child is actually dependent for support upon the grandparents.

My amendment re-defines the term "child" so that benefits would be provided for a grandchild if, at the time the grandparents died or became entitled to benefits, he had been living with the grandparents at least 1 full year—except in the case of death or disability of the grandparents within the same year as the loss of support from the parents. In addition, it would have to be shown that the grandparents actually furnished at least one-half of the child's support during this time.

Adoption of the measure would correct an anomaly in the social security program. It would make actual dependency the criterion for payments to a grandchild.

Although this is not a major change when measured in terms of the number of people affected, it is nonetheless a major change when measured by the effect it will have on the incomes of those individuals who will qualify for benefits. Moreover, the social security actuaries inform me that because only a relatively few people (about 200) could be expected to qualify for benefits, adoption of the proposal would have no significant effect on the total cost of the social security program. (The level-cost would be 0.01 percent of the taxable payroll.) While my amendment applies only to grandchildren, the Committee may very well wish to expand this legislation to cover other related children who find themselves in similar circumstances.

My second suggestion is in connection with the removal of "relative responsibility" clauses in titles X, XVI, and XIX of the Social Security Act.

At present, title XIX of the Social Security Act (Medicaid), in determining eligibility for the extent of medical assistance to be available to individuals, states that "the financial responsibility of any individual for any applicant or recipient of assistance under the act should not be considered unless such applicant or recipient is such

individual's spouse or such individual's child who is under age 21; or is blind or permanently disabled.

Titles X and XVI (Grants to States for Aid to the Blind; and Grants to States for Aid to the Aged, Blind, or Disabled) also have the effect of allowing States the latitude to set up "relative responsibility" regulations. In other words, blind or permanently and totally disabled persons over 21 must, in many cases, prove that their parents do not have the financial ability to meet their medical—or other—needs. The law subjects blind persons to a humiliating and unfair discriminatory practice, in that they are essentially expected to bankrupt their parents before receiving Federal assistance, while nondisabled, but needy persons are not expected to prove their parents are unwilling or unable to help them.

When one considers the hardships caused by blindness, and the courage and self-confidence necessary to overcome this handicap so as to function in a dynamic society, it seems even more unfortunate that blind persons must face a humiliating, painful, and unnecessary experience before qualifying for assistance they might need. The sense of independence and self-respect that a blind adult can acquire by knowing he is no longer a burden to him family may make a significant impact on his level of aspiration and ability to move forward into real independence.

Again, I am urging the passage of legislation which would not affect a large number of people. It is estimated that only about 1,000 people would be affected by this proposal, but its passage would end a discriminatory, highly offensive practice for those who are affected.

My personal interest in this is in having had in childhood a blind piano teacher; in having lived near and worked with the Lighthouse for the Blind—a beacon of hope to thousands of blind people throughout the world in Winnetka, Ill., for 20 years; and in having been an employer for 25 years when I found that blind people can be employed in many ways and in very useful occupations. I think our company had a very high ratio of blind persons who were given hope through this employment, and that is why I have continued my interest in trying to find ways in which we can remove discrimination against them.

The CHAIRMAN. May I say that this "relative responsibility" has never had any great appeal to me, because I recall very much how we found in many States they were using "relative responsibility" as an excuse to keep those people off the rolls and according assistance to them.

What good does it do some poor devil if he has a relative who can help him if the relative won't help him. So to say "in view of the fact that a person has a relative who is unwilling to help, we won't help," is really a pretty sad situation.

If he has a legal right to make that relative contribute and has not exercised that legal right, then I think we have a right to say, "Well, now, if you have a legal right to sue, let's say, your father or your son, as the case may be, to help you, and you haven't availed yourself of your rights, we are not going to pay our money because legally they ought to pay," but where you have no right to make the relative put the money up you are just saying you are not going to contribute because there is a relative who could help but won't. That puts us in

the position of being just as cruel as the relative who won't help his needy blood kin.

Senator PERCY. Thank you, Mr. Chairman.

I will just, in the interest of time, go right on to the last three which are quite short but reach a much more wide-sweeping situation in their implications.

Third is the increase in, and eventually, limitation of earnings limitation.

In May of this year the House of Representatives acted favorably upon a proposal to raise the present earnings limitation of $1,680 on social security benefits to $2,000. In January of 1971, recipients between the age of 65 and 72 (the "retirement test" does not presently apply to those over age 72) would receive the full amount of their benefit each month if their annual earnings did not exceed $2,000.

Almost daily I receive letters from constituents who are trying to supplement their fixed social security incomes by working—they are trying to fight inflation the only way they can—and they cannot understand why they are penalized for doing so. Why, when America places such a high value on industriousness and productive labor, do we penalize our older citizens when they wish to exhibit these desirable qualities? The retirement test, in keeping many older persons from working, also results in a loss to the country of their valuable skills and productivity.

I therefore urge the committee to act favorably on my proposal to raise the earnings limitation to $2,400 immediately, and phase this limitation out completely over a period of 7 years.

FULL BENEFITS FOR WIDOWS

Dollar for dollar, no change in the present benefit structure would more effectively reach those at the margin of subsistence than elimination of the widow's discount. The Social Security Act discriminates at the present time against widows and widowers of primary beneficiaries. A man can draw 150 percent of his monthly benefit if he is married. If he is a widower, he receives his full benefits—or 100 percent. But if he leaves a widow, she can receive only 82½ percent of his total allotment. This situation creates a serious injustice. A widow's expenses are hardly less costly than a man's. I never found the women in my family could live more cheaply than a man. It is a cruel blow for a widow when she loses not only her husband on whom she depends for financial advice, but also loses almost half of her income at the same time. What does she do—for instance, to cut her housing expenses in half? Women who lived a decent but modest life with their husbands while they both received social security, must often go on welfare when their husbands die. We hear more every day about "equal rights for women." With a provision like this in the present law, no wonder there's a women's liberation movement.

I therefore strongly urge the committee to retain the provision in the House-passed bill which provides for full benefits for widows.

AUTOMATIC BENEFIT INCREASES

Certainly when we have a great auto industry, a major manufacturer, shut down, and one of the points of dispute is the right for automatic increases in the cost of living, then it is evident that retired

people are paying a very cruel price now for the increasing costs of inflation. As time goes on, their living standard goes down as the cost of living goes up.

I therefore would like to express my hope that the committee will keep the provision in the bill which provides for automatic benefit increases to correspond with rises in the cost of living. This is absolutely essential if we are going to fulfill the original purpose of social security of offering a "floor of protection" to the retired, disabled, or surviving dependents of a worker. It is essential if we are going to offer these people some insurance against inflation, as well as against the politics which inevitably come into play when benefit increases are considered. Why, when regular wage earners have automatic wage escalators built into their contracts, should only the retired pay the bitterest price of inflation?

This country seems amazingly preoccupied with the problems of youth, and while I certainly believe these problems deserve our serious and careful attention, I am highly distressed by the apparent lack of concern and attention that I see on the part of some parties, certainly not the members of this committee, toward the problems of the elderly. Far too often the lives of these individuals are led in loneliness and despair. We now have an excellent opportunity to help these people, and I would just commend this committee for what it has done in the past in showing its deep concern for the aged, and I trust that it will continue these enlightened policies in the future.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator BYRD. Mr. Chairman, before the Senator from Illinois leaves, may I say that I feel he has presented an excellent statement to the committee this morning. I am interested in all of it. I want to particularly mention your suggestion that the increase in earnings limitation be increased from the present $1,680 to $2,400. I note we were proposed to increase it to $2,000 but I am inclined to the view that you express that that limitation should be raised beyond $2,000.

Overall, Mr. Chairman, I think the Senator from Illinois has presented a very interesting and provocative statement this morning.

Senator PERCY. I thank my distinguished colleague from Virginia. Thank you very much.

The CHAIRMAN. Next we will call Senator Harrison Williams of New Jersey.

Senator Williams, we appreciate your courtesy and kindness to your colleague as well as this committee and we welcome you.

I noticed you have associates here that you wish to have accompany you at the table.

STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A U.S. SENATOR FROM THE STATE OF NEW JERSEY

Senator WILLIAMS. Thank you, Mr. Chairman, and members of the committee. I appreciate the opportunity to appear here today to discuss a matter of vital importance for over 20 million older Americans, the need for major improvements in social security and medicare.

I certainly want to express, as a member of the Senate, deep gratitude to you, Mr. Chairman and members of this committee, for the breadth, depth, alertness, and expedience of the committee's action on this bill.

47-530—70—pt. 2——15

I believe it has been stated that I would like to ask unanimous consent to put my statement into the committee's hearing records in the interest of time, and yield the time allowed to two distinguished experts from the State of New Jersey, Mr. Eugene J. Friedman, president of the New Jersey Nursing Home Association, and Dr. Claude Roe, assistant executive director of the Presbyterian Homes for the Aged. They will address themselves to the provisions of H.R. 17550 affecting medicaid and Federal reimbursement for nursing homes, mental institutions, and hospitals.

With that, Mr. Chairman, I would appreciate——

The CHAIRMAN. You would like to have your statement printed and you would like for them to use your time?

Senator WILLIAMS. Exactly.

The CHAIRMAN. Without objection that will be done. We will adopt that procedure.

Senator WILLIAMS. I am not running out on my distinguished constituents, but I have a Labor Committee meeting at 10:30.

The CHAIRMAN. You have a good statement, and we all read it with great interest.

I want to ask you one question about your statement, though, Senator, before you turn this over to those two witnesses. What is the dollar cost of your proposal and exactly how much taxes do you recommend to pay for it?

Senator WILLIAMS. Well, it is spelled out pretty much in the statemen. I do incorporate the proposal that general revenues be included as part of the financing, developing on a small base and over a decade coming to approximately one-third of the cost of some of the programs under social security.

The CHAIRMAN. This program you are recommending would do a lot for a lot of people. I point out that it costs a lot of money and I take it you are not backing away from the cost of it.

Senator WILLIAMS. No, not at all. Many of the provisions I have recommended would actually cost less than other proposed reforms—such as the increase in the annual earnings test to $2,100. This is less than what Senator Percy recommends. I put it at this figure because I believe this amount is a more workable figure, although I do not oppose the $2,400 earnings limitation.

In addition, my amendment would be phased in over several years. Moreover, based upon the sound growth of the social security trust fund and our economy, these needed reforms can be adopted without jeopardizing the soundness of the program or imposing burdensome taxes on today's workers.

The CHAIRMAN. Well, thank you very much, Senator Williams.

Senator WILLIAMS. Thank you.

(The statement and attachments follow. Hearing continues on page 565.)

TESTIMONY BY SENATOR HARRISON A. WILLIAMS, JR.

Mr. CHAIRMAN, I appreciate the opportunity to appear here today to discuss a matter of vital importance for our 20 million older Americans—the need for major improvements in Social Security and Medicare.

Thirty-five years ago this Nation made a commitment to enable the elderly to live a life of dignity and self-respect in retirement with the enactment of the historic Social Security Act.

Today Social Security protects workers and their families from loss of earnings because of retirement, death or disability.

Without these benefits, many older Americans would be forced to go on the relief rolls or to depend upon relatives who frequently would not have the resources to support them.

And without these benefits, 19 out of 20 beneficiaries would not even achieve a moderate standard of living.

Yet, the vast majority of elderly persons are experiencing a retirement income crisis which is worsening, rather than improving:

Nearly 5 million senior citizens live in poverty;

Over 2 million are on welfare; and

Medicare, even though it has brought peace of mind to millions, still only covers about 45 percent of their health care expenditures.

Today elderly persons are twice as likely to be poor as compared to younger persons. One out of every four persons 65 and older—in contrast to one in nine for younger individuals—now lives in poverty.

Moreover, the older population is falling further and further behind in terms of economic well-being.

Older Americans now comprise 10 percent of our population, but constitute nearly 20 percent of our total poverty population. In 1968 they were 18 percent of the total number of persons in poverty.

More importantly, the new preliminary Census Bureau statistics for 1969 reveal that the aggregate number of elderly persons living in poverty has actually *increased* by 157,000 since 1968—from 4,630,000 to 4,787,000. In sharp contrast, the number of younger persons who would be considered poor declined by 1,257,000—about a 6 percent reduction.

These figures clearly show that piecemeal, stop-gap Social Security measures are just not going to work. Today's retirement income problems cannot be solved by adding a few dollars every year or two to Social Security.

Immediate and far-reaching action on several fronts is urgently needed now to modernize Social Security and Medicare.

HOUSE-PASSED SOCIAL SECURITY BILL

The House-passed Social Security bill, H. R. 17550, certainly takes several steps in the right direction. It contains, I am pleased to say, several proposals I have advanced—such as a raise in benefits, 100 percent benefits for widows, liberalization of the earnings test, an age-62 benefit computation point for men, provision for cost-of-living adjustments, and other important measures.

Yet, more is needed to improve this vital, but still imperfect program.

In May, I introduced an omnibus amendment—cosponsored by Senators Hartke, Hart, Muskie, Eagleton and Tydings—to implement these necessary changes.

Today I urge you to incorporate these vital reforms in the bill which will be reported out by the Committee.

TWO-STEP INCREASE FOR 1971 AND 1972

The 5 percent increase voted by the House is certainly most welcome, but it will not become effective until January 1971.

In the meantime, our cost-of-living has been rising at an annual rate of about 6 percent—the worst rise in nearly 20 years.

At this rate, the 5 percent benefit increase would be wiped out even before an older person received his first Social Security check reflecting this increase—in February 1971.

Spiraling inflation continues to rob the pocketbook of every American, but no group is hurt more badly than older Americans living on limited, fixed incomes.

As prices go up, their meager purchasing power goes down—usually quite sharply.

A 5 percent rise is simply not adequate if the elderly are to win their desperate race with inflation.

For these reasons, I believe that Social Security benefits should be raised by 10 percent by January 1971, rather than 5 percent.

For an average retired couple, this would mean an additional $118 in annual benefits above the House level.

Moreover, I believe a further increase is needed in 1972—a 20 percent raise.

COST-OF-LIVING ADJUSTMENTS

Thereafter, benefits would be automatically adjusted for corresponding raises in the cost-of-living.

H.R. 17550 also provides for a similar automatic escalater, but it would go into effect after today's inadequate benefits had been raised by only 5 percent.

A cost-of-living adjustment mechanism, I believe, is essential to protect the elderly against inflation.

But, benefits must be raised to a more realistic level than provided in the House bill before this automatic escalator is employed.

LIBERALIZATION OF THE EARNINGS TEST

H.R. 17550 also raises the $1,680 annual earnings test to $2,000 before Social Security benefits would be reduced.

This is certainly an important step forward, but I believe a more realistic amount would be $2,100.

This additional $100 would be particularly helpful for older Americans who must work to supplement inadequate Social Security benefits.

Yet, the added cost of this proposal would be very modest.

MINIMUM BENEFITS

One glaring omission in the House bill is the failure to come to grips with the problem of minimum benefits.

Minimum benefits for a single person now amount to $64 a month.

Because of the existing inadequate base, a 5 percent increase will raise the minimum by a miniscule $3.20 per month—from $64 to $67.20.

Now, the poverty index for a single person in an urban area is around $1,840. Under H. R. 17550 minimum benefits would be about $806 a year—less than one-half of the poverty threshold.

This is only a token amount and completely inadequate for a person subsisting in poverty.

Because of the widespread existence of poverty among older persons, I propose that the minimum level for a single person be raised substantially—to $90 a month in 1971 and then to $120 in 1972. This initial increase could help remove 1.4 million older Americans from the poverty rolls.

EXTEND MEDICARE COVERAGE TO OUT-OF-HOSPITAL PRESCRIPTION DRUGS

Another major area of reform is health care. Even with Medicare, the threat of costly and catastrophic illness still remains all too real among out aged population.

Health care expenditures per aged person average about 2¾ times above those of people under 65.

One major expenditure for the elderly is prescription drugs which represent about 20 percent of their personal health expenses. Although the aged constitute about 10 percent of our total population, they account for nearly 25 percent of all prescription drug costs. And, their annual per capita expenditure for drugs is more than three times as great as for persons under 65.

A Department of Health, Education and Welfare report recently concluded that the disproportionately high expenditures among the aged, combined with a widespread inability to pay for such drugs "may well be reflected in needless sickness and disability, unemployability, and costly hospitalization which could have been prevented by adequate out-of-hospital treatment."

Therefore, I urge coverage of out-of-hospital prescription drugs under Medicare.

OTHER REFORMS

Other measures are also needed now to provide comprehensive reforms within Social Security and Medicare.

In addition, I would urge:

Provision for well-timed and well-conceived use of general revenues to finance a portion of the Social Security and Medicare programs;

Extension of Medicare coverage for disabled Social Security beneficiaries under 65;

Liberalization of the eligibility requirements for disability benefits;
Broaden Medicare to cover other needed items, including eyeglasses, dentures and hearing aids; and
Revision of the method for computing Social Security benefits.

DELETE SECTION 225 (a)

Mr. Chairman, my earlier comments have been confined to proposals for improving H.R. 17550.

Now I would like to turn to a provision which I believe should be deleted.

This measure is section 225(a), which is designed ostensibly to establish incentives for states to employ outpatient care under Medicaid.

But, I fear that this controversial provision will deal a crippling blow to the availability or quality of care fore Medicaid partients in general hospitals, tuberculosis treatment centers, nursing homes and mental institutions.

Particularly shortsighted is the proposed ⅓ Federal cutback in funding after 60 days for patients in hospitals or 90 days for persons in nursing homes or mental institutions. This is in spite of the fact that ⅔ of all nursing home residents require more than 90 days care.

Since Medicaid patients are unable to pay for their own medical care, this crushing burden will fall directly on the states. And we know already that virtually every state in the union lacks sufficient resources to assume this additional substantial burden.

In my own state of New Jersey, the cost will be $25 million over a two year period. Approximately 18,000 Medicaid patients in New Jersey nursing homes, mental hospitals, general hospitals, and tuberculosis hospitals may suffer from this ill-advised measure.

For these compelling reasons, I recommend the deletion of section 225(a) from the bill.

PETITIONS FROM THE ELDERLY

In concluding, I would like to say that the response to my omnibus amendment has been truly magnificent. During the past few months, I have personally received more than 8,000 petitions from all over the Nation, including over 6,000 from my own state of New Jersey. These petitions, I might also add, have come from younger persons as well as the elderly.

They have enthusiastically expressed support for these measures. In addition, they have called upon me to urge you to adopt these necessary provisions.

When President Franklin Roosevelt signed the 1935 Social Security Act, he said, "This law . . . represents a cornerstone in a structure which is being built but is by no means complete."

The time has come to make major improvements in this program—as well as Medicare—to build a solid foundation for greater economic and health security in retirement.

Mr. Chairman, I also ask unanimous consent to submit two statements presented by Dr. Solomon Geld and Mr. Eugene Friedman at a hearing conducted by the Senate Committee on Aging at Ocean Grove, New Jersey. This testimony, I believe, will be helpful in the Finance Committee's deliberations.

In addition, I ask unanimous consent that a letter sent from New Jersey Governor William Cahill be included in the hearing record. This letter helps to document the potentially harmful impact for New Jersey and other states if section 225(a) is enacted into law.

Moreover, in the near future I shall be submitting additional information for the record about section 225(a) and other major provisions. affecting older Americans.

(The statements and letter follow:)

[Excerpt from hearing before the Aging Committee]

Dr. GELD. What is the difference between person and patient.

Of course, all aged patients are persons and all aged persons are sometimes patients.

There is, however, a functional difference between them in relation to the length, character and intensity of a pathology and the restorative potential.

There is also a difference between person and patient in the dimension of living, in life's cycle and life's satisfaction.

The question about a patient and his needs versus a person and his needs is one of changing focus.

The rights and obligations of a person stand in reverse proportion to the intensity of a struggle for physical survival.

The more dangerously ill a person is, the more attention he requires as a patient, during which time his needs as a person are held in abeyance.

Nobody asks a patient on the operating table about his food preference.

On the other hand, with the passing of danger and assurance of survival, a gradual shift of emphasis occurs. The medical needs which, during the period of acute illness were in the focus, move to the periphery.

Personal and social needs, which were in the periphery during the acute illness stage, move to the center.

Every occupant of a health-care facility is, strictly speaking, a patient for a short time and a recuperating person with growing personal and social needs for a longer time. This is so in any age group, but especially in the higher age brackets where a post-hospital situation of the discharged patient calls for an increased amount of social and personal care in proportion to his advancing age, disability and impaired psycho-physical health equilibrium.

Having defined the changed functional relationship between patient and person, we have also spelled the functional difference between a hospital and a nursing home and the rationale for the latter.

Nursing homes, proprietary and nonprofit alike, came into being at least partly, in response to a quest for meeting the vital personal, social and medical needs of an individual who could not or would not have these needs met in his own home.

Why this is so is another story. Whether it should be so is still another story.

One thing is sure. Instead of projecting a world of saints we should understand that placing an aged person in a nursing home is not the worst of the sins of western civilization.

I emphasize: the recuperating person, depending on his functional deficit, has personal and social needs. Meeting these needs is an integral part of the therapeutic process and of restoration of personal and social function.

It is not a superfluous appendix.

At this point, permit me to introduce a synonym of personal needs, one which is very much in use, namely, A.D.L.: Activities of Daily Living.

These range from getting into and out of bed, grooming, bathing, dressing, eating, various degrees of walking, and so forth, towards more advanced activities such as reading, writing, communicating, participating and being motivated for purposeful living.

Think of these and similar A.D.L.'s and think at the same time of the population of the majority of good nursing homes, and you will realize that the bulk of their direct services to the individuals within their walls revolve around the above-named functions.

They constitute, as a rule, an individual's greatest need and hope at the point of intake into a nursing home.

The improvement of a person's A.D.L. capacity, not the skilled nursing and medical services, is the part of the nursing home's program that consumes the bulk of service time.

This is why good nursing homes are multi-care facilities, geared to the different functional capacities of the clientele with much space, staff and time allotment for promoting A.D.L. and much less time, space and personnel for medical service and skilled nursing.

Good nursing homes aim to prepare some of their clients for return to their social setting whenever possible. When that is not possible we must try to create an environment within the nursing home that will approximate the former home environment of the client.

What do we mean by social needs?

The Bible teaches us that it was not good for Adam to be alone.

The modern existentialist philosopher, Heidegger, said that "to be" means to be here and now (Dasein). It also means to be with (Mitsein).

Both quotations represent an insight that the term "human being" is an abstraction, that in reality we know Mr. Jones and Mrs. Smith and their particular environments.

By way of comparison, we may say that while we isolate individal words in a dictionary, a live language is characterized by a relationship of words.

A mere string of words is gibberish, not language.

The mere presence of many unrelated individuals in physical proximity is not society.

What syntax is to language, social interaction is to society. It is in social relationship, beginning with the family members and growing with the development of individual capabilities, that the person finds his social fulfillment, irrespective of whether this relationship unfolds through the actual physical presence of others or whehter it exists in the person's mind.

Therein lies the difference between the loneliness which we know can occur in a crowd, and solitude, which can embrace thousands in a meaningful, imaginary relationship in a mind's eye.

The fundamental social unit is the family. The family is the primary answer to a person's social needs. Where that primary answer is not possible because the person has no family, or where the family deviated seriously from the norm of wholesome and beneficial relationship, or the condition of the person would adversely affect that norm, we create social substitutes.

In terms of social needs, the institution for the chronically ill is that social substitute.

Its social task, therefore, is to utilize, as much as is feasible and desirable the existing symbiosis of the person with his family and/or friends and, over and above that, to transform a crowd of people living in an institutional setting next to each other into a community of people living with each other.

Community means that its members have something in common or create something in common.

The more common denominators, the more cohesive is the community. That such a community can have a therapeutic effect has been amply demonstrated by Maxwell Jones who created this kind of a community to deal with World War II veterans suffering from industrial neurosis.

The therapeutic community in a nursing home of which a person becomes either temporarily or permanently a member, is a structure in which sizeable personal and social needs interlock with peripheral medical and nursing needs.

This principle governs long-term hospitals, skilled nursing care facilities, extended care facilities, intermediate care facilities, in short, all post-acute hospital congregate, social and health-care settings.

Therefore, in all of them we must learn to strike a balance between care and self-care, to divide the time in consideration of a person's need to be alone and to be with others; to establish a harmony between freedom and authority, between reliable dependence and opportunity for independence; to balance the distribution of space in consideration of the old person's perception of space, private, semi-private, public, with an opportunity for both privacy and socialization with small and large groups.

In my written testimony, I have elaborated on the shortcomings of Medicare in the light of this philosophy, which I assure you is the fundamental stance of all sheltered, social and health-care facilities under philanthropic auspices.

I know this to be so because I am closely identified with such auspices, being a charter member of the American Association of Homes for the Aging, the past president of both the New Jersey Association of Homes for the Aged and the National Association of Jewish Homes for the Aged.

These shortcomings apply equally to Medicaid situations, the standards of which are close to those of Medicare, and to a lesser degree, even to the intermediate care establishments.

We just cannot square the philosophy, the tradition and moral mandate of continuity of care of the total person and meeting his fluctuating needs with growing fragmentation of care and fragmentation of reimbursement.

Both fragmentations are, regrettably, imitations of the hospital establishment and its patient orientation. They don't take into account the distinction between a short-term hospital and a long-term post-hospital setting.

Whereas in a short-term hospital the patient, as a rule, comes in for a specific diagnosis and therapy in a specific department, he certainly does not need pediatrics or maternity, in a long-term setting the same aged person moves from a status of ECF case, skilled nursing case, ICF case and shades of inbetween, and this happens in frequent intervals which one can never chart in advance with any degree of accuracy.

Nothing but a multiple-function post-hospital congregate social and health-care facility with established range of services geared to the needs of the aged person who is sometimes a patient (having a range of health deficits from sub-

total sufficiency to total dependency), nothing but an overall reimbursement cost based on the accounting of total expenditures for all, each according to his needs, will do justice to our concept of the dignity of the aged person and how to maintain it.

I am equally convinced that Government will save money by doing away with fragmentation of care and fragmentation of reimbursement.

The aged would get better service at less cost.

I realize that the present structure cannot be changed in short order, but I am suggesting that what I have formulated deserves serious experimentation.

Since philanthropic long-term health-care facilities, under civic and church sponsorship represent only eight percent, I am told, of the country's total nursing bed capacity, and of these eight percent only some are multiple-function health-care centers, they lend themselves ideally to such experimentation without disturbing the present structure for the great majority of nursing beds.

Our traditional concern with and performance for the aged, our lack of profit motivation, or our personal and material participation in public welfare, makes our moral stance and interest equal to that of Government.

In the light of what I have said and written to you, we can assess a measure of progress and failure of the Country's concern and action with and for those aged whose functional status fluctuates between patient and person. This I believe:

With Medicare and Medicaid, we reduce the dimension of physical suffering. We have not increased the dimension of living and we have a long way to go.

Government and society pay much more attention to the aged patient than to the aged person. Rejection of an elder is compatible even with good medical care. It is incompatible with appreciation of dignity of the aged person.

We have mitigated the punishment of old age; we have yet to increase its rewards. We have relieved the precipitous decline, the bitter fate of the aged patient (becomes a doubtful favor); we have not enhanced the yearned-for fulfillment of the aged person.

Whether there is hope in this direction will depend upon the moral stance of society and its priority decision in relation to the aged.

Such a stance was expressed by the famous Rabbi A. J. Heschel at the first White House Conference on the Aged in 1961 when he reminded the audience that according to the Talmud, one is permitted to pawn the holy scrolls of the Biblical scriptures for the sake of the old person.

Senator WILIAMS. Doctor Geld, we are running into the later planning period for the next White House Conference——

Dr. GELD. Yes, sir.

Senator WILLIAMS. And you are a part of that?

Dr. GELD. I hope to be. I have not been asked as yet.

Senator WILLIAMS. I do not know if I have any standing to ask you.

Dr. GELD. At the last White House Conference, I was not involved, but I was to represent two national organizations. I did not represent the State, but I participated in the Conference, and particularly on the panels of long-term medicare, as delegate of these two organizations.

Senator WILLIAMS. I hope you are a part of it, and I am certainly grateful that you have been a part of our hearing here today.

Dr. GELD. I am very happy to be here, and to be a part of this fine hearing. I thank you very much.

Senator WILLIAMS. Thank you very much.

Senator WILLIAMS. Our next speaker will be Mr. Eugene Friedman, F.A.C.-N.H.A., President of the New Jersey State Nursing Home Association.

Mr. FRIEDMAN. I thank you, Senator Williams. This is the second time I have had the pleasure of speaking before this group in these hearings.

I can say that a great deal of emphasis today was put on the non-profit institution.

Although as President of the Nursing Home Association, I represent both non-profit and proprietary I have no intention of defending the cause of one over the other.

For in the defense of proprietary, one must mention the word "profit" or "return on investment."

Unfortunately of late these have become dirty words in a country who greatness has a direct relationship with them.

I do not intend to use "dirty words", so I am going to answer Senator Williams' question that he asked this morning in his opening address.

He said, "We should look at the grassroots level and get the true picture." What really has been the effectiveness of a given program? How has the program been of benefit, not only to the individual at whose well being it was aimed, but to the entire community?

To answer this I must in all clear conscience say that Medicare (Title 18, Part A) has turned out to be a big failure.

This was the most ambitious piece of social legislation our country has ever undertaken, and we are letting it die.

Why are the nursing homes or as the Government calls them, extended care facilities, dropping out of the program all over the country?

Now our neighbors, New York State nursing homes, are refusing Medicare admissions.

I will not attempt to take the time of this hearing to list all the inequities of the program. I must, however, speak of one that has hurt the public, the community and the nursing home.

I use the words "nursing home" instead of "extended care facility" only because I feel most of us are more familiar with it.

The gremlin or cancer that is eating away the foundation of the Medicare program is called "Retroactive Denial" or "cut-off" from day of admission.

I will explain how this is costing the Government hundreds of millions of dollars.

Costing the public both in money and health and is helping to take participating nursing homes out of the program.

Something must be wrong. Take Ocean County where I live. We have about 54,000 senior citizens over sixty-five. Yesterday, the total Medicare census in nursing homes was forty. We have three hospitals in the County. Call them, ask them for a bed in the hall, not a room.

Now, I will explain why this is happening. In order for you to get a clear picture of what the impact of these "retroactive denials" are, I will give you a typical situation of what has been happening all over the country.

A physician transfers his patient from the hospital to the nursing home as soon as he feels the acute stage of illness is over.

He tells the family that the patient no longer needs the hospital but will get the required service at the nursing home.

The patient is admitted on the certification of the doctor. At this point usually an R.N. in the nursing facility makes out a form called a "check-off list" on which she checks off various conditions from the patient's chart. This goes to the fiscal intermediary who, in this State, is usually either Blue Cross or Prudential.

Someone, I say someone, because we are told it is either a clerk, a nurse, or a doctor, makes a decision on whether the Government will cover this case or not.

Up until recently, we were told the patient would have to meet a certain "medical criteria."

Now, that has changed so that the patient must meet an "insurance criteria."

In an increasing and alarming rate, many, I venture to say, too many are being refused benefits.

The call comes through that the patient is being denied benefits retroactive from the day of admission. This call usually comes about ten days after admission.

Now, the facility turns to the family and asks for payment. After all the nurses, the suppliers, the bank, and so forth, are not interested that the Government refused to pay for the patient.

To this point we have hurt the patient both in health and in pocket. The nursing facility has been placed in the role of the villain because they must insist on payment from the family.

Now, the family turns their wrath on the doctor. After all, wasn't it he who said to move the patient?

As long as the patient was in the hospital Medicare paid the bill. The doctor now, after being "dressed down" by the family, begins to wonder. By moving the patient to the nursing home, he was going to save the Government money.

We all know that hospital care costs more than double that of nursing home care. In doing this, he takes on much paper work, which he hates, and now he finds that his medical decisions are being challenged.

He has taken abuse from an irate family. All this because of "miraculous ambulance cure."

That is while the patient is in the hospital they are sick enough to be covered. The moment they are transferred to a nursing home, they are no longer sick enough to receive the benefits.

Now, the physician has become reluctant to transfer his patients. Now, they stay longer in the hospitals and so cost the Government additional millions of dollars. This retroactive denial of benefits must be corrected. It is helping to destroy the medicare program.

If S.S.A. will only listen and they will if you, the public, ask them to.

STATE OF NEW JERSEY,
OFFICE OF THE GOVERNOR,
Trenton, August 31, 1970.

HON. HARRISON A. WILLIAMS, JR.,
U.S. Senate, Committee on Labor and Public Welfare,
Washington, D.C.

DEAR PETE: Your letter of August 5th asked that I furnish you with additional information which you need in connection with the provisions of H.R. 17550 which follows:

1. The number of patients, expressed in round numbers, currently in specified medical institutions and eligible for Medicaid are as follows:

Nursing homes	9,500
General hospitals	5,000
Tuberculosis hospitals	10
Mental hospitals	3,400

2. In the absence of limiting amendments to the present New Jersey program, the effect of 225 (a) would be to shift a portion of ongoing health services costs for these groups from the Federal Government to the State. It is estimated that on an annual basis this would amount to:

Nursing homes	$7,500,000
General hospitals insignificant	[1]
Tuberculosis hospitals insignificant	[2]
Mental hospitals	9,175,000

[1] Few patients exceed 60 days length of stay.
[2] Small patient load will continue or decrease.

3. Outpatient facilities in the State number 108, most of which are small, provide a limited range and volume of services, and are poorly distributed geographically, in relation to need. Needs are particularly acute in center city and rural areas.

The State Hill-Burton agency reports that 47 of the existing 108 facilities need to be modernized or replaced, and that 4 new facilities are currently needed. In 8 of the 12 health facilities planning areas in the State, less than 75 percent of the needs are being met; only about 80 percent are being met in the remaining 4 areas.

4. The details on the general estimates are provided in Mr. Poinsett's memorandum attached.

The memorandum from Mr. Poinsett which you indicate was not enclosed with my letter of July 31st is attached hereto. I regret that it was overlooked.

Should there be any additional information which you feel is necessary, please do not resitate to ask for it. Certainly, every effort must be made to save New Jersey harmless from any adverse provisions of H.R. 17550.

Sincerely yours,

BILL, *Governor.*

DEPARTMENT OF INSTITUTIONS AND AGENCIES,
INTER-OFFICE COMMUNICATION,
July 29, 1970.

To: Dr. Lloyd W. McCorkle, Commissioner.
From: A. Wright Poinsett, Acting Director, Division Medical Assistance and Health Services.
Subject: H.R. 17550.

This is in response to the July 17 memorandum from Dr. Kott, regarding the letter from Mr. Wechsler, concerning H.R. 17550.

Miss Kern of the HEW Regional Office in New York has advised "that all States with which she is acquainted have instructed the congressional delega-

tions of the impact of this legislation would have on their respective States." While there is some indication that Congress will not give favorable consideration to H.R. 17550, it is suggested that the Governor advise New Jersey's congressional delegation of the consequences to the State in the passage of this legislation.

H.R. 17550 includes many changes; some which are designed to purchase improvements in Title XIX. In addition to the administrative modifications and improvements, there are important fiscal changes covering Federal participation as cited in Mr. Wechsler's letter dated July 15.

A. The bill provides for a decrease in Federal participation for acute hospital care after 60 days.

There would be some loss in Federal participation for this segment; however, there are very few HSP patients in acute hopsitals beyond 60 days.

B. The bill provides for a decrease in Federal participation for HSP patients in skilled nursing homes after 90 days.

The estimated yearly loss in Federal participation (and added State costs) for this segment would amount to about $7,500,000.

C. The bill provides for a decrease in Federal participation for HSP patients 65 and over in public mental and tuberculosis hospitals after 90 days, with complete elimination of Federal participation after an additional 275 days.

The estimated yearly loss in Federal participation (and added State costs) for this segment would amount to about $2,175,000. Reductions in subsequent years will be from $6,000,000 to $7,000,000 as a result of the complete elimination of Federal participation after 365 days.

D. The bill provides for a reasonable cost differential between reimbursement for skilled nursing home care and in intermediate care facilities.

This would only be significant if the State does not establish intermediate care facilities.

The HEW representatives have advised that there has been many amendments under consideration at this time; as a result, the House staff has not prepared the usual fiscal estimates.

The CHAIRMAN. Now, we will hear from your guests.

STATEMENT OF EUGENE J. FRIEDMAN, PRESIDENT, NEW JERSEY NURSING HOME ASSOCIATION

Mr. FREIDMAN. Mr. Chairman and members of the committee, my name is Eugene J. Friedman, and I am president of the New Jersey Nursing Home Association, located at 32 West State Street, Trenton, N.J. I am president of the Town and Country Nursing Centers, a New Jersey licensed nursing home administrator and a fellow of the American College of Nursing Home Administrators. The New Jersey Association is a voluntary organization and represents some 145 nursing homes, with 9,500 beds both proprietary and nonproprietary, which provides services to the elderly citizens in the State.

My main purpose in appearing before this distinguished committee today is to bring a special message to you in behalf of those nursing home facilities in New Jersey which participate in the title XVIII and title XIX—medicare and medicaid—programs.

First, let me say that the State of New Jersey did not jump into the medicaid program immediately. Careful and deliberate study was given to the type of program that should be initiated in the State—giving full weight to the services to be provided and the financing of such services on a partnership basis with the Federal Government. As a result, New Jersey implemented only a minimal program covering the categorically needy.

Under a wholly financed State program we do cover the needs of the medically indigent aged. There are some defects, however, which

need immediate attention to eliminate hardships our elderly citizens and the providers are experiencing in New Jersey and elsewhere in the country.

In this connection, we enthusiastically support section 233 of H.R. 17550, which provides for advance approval of extended care coverage under the medicare program. We feel this is a step in the right direction in eliminating countless retroactive denials of benefits to beneficiaries who are eligible for such benefits under the medicare program. Retroactive denials to eligible beneficiaries, brought on by complicated and strict admission requirements set by fiscal intermediaries under edict from the Department of HEW, are a widespread problem and have been given serious attention by several congressional committees. I am especially pleased that the Senate Committee on Aging, under the leadership of Senator Harrison A. Williams from my home State, has brought this problem into full focus during hearings held earlier this year. At that hearing, Senator Williams said:

> For most extended care facilities, it is extremely difficult to determine with any degree of certainty which patients will be covered. This is true, although a competent physician certifies in writing that the patient needs extended care. Because of the problem, many doctors are reluctant to refer needy patients to nursing homes for extended care—even though such care would be of important therapeutic value and less costly than continued hospitalization.
>
> The net effect is to increase hospital stays and to reduce days of nursing home car·. although this care may cost the government only one-third of the amount for hospitalization. Many doctors believe that it is preferable to leave the patient in a hospital for convalescence rather than to submit him to such uncertainty. However, shaving one hospital day from Medicare's national average could result in a savings of $400 million."

We, in New Jersey, are pioneering in an effort to rectify this condition in cooperation with the New York regional office of the Social Security Administration, fiscal intermediaries, the New Jersey Hospital Association, and the New Jersey Medical Society. We are now in the process of requesting authorization for a pilot program of advance approval for ECF care. Such approval would be given by areawide utilization committees while the patient is still in the hospital. This basic principle will eliminate the hardship of retroactive denials.

Mr. Chairman, section 233 would write this principle into law and do much to assure that beneficiaries under the medicare program will receive their rightful benefits.

Mr. Chairman, there is another provision in H.R. 17550 which, if adopted, would have a severe and adverse impact on nursing home services in the State of New Jersey and elsewhere in the country. I am, of course, referring to section 225, which is designed to cut back Federal matching funds after a patient has received 90 days of skilled nursing home care under the medicaid program. This provision goes contrary to the laudable goals of the medicaid program when it was first proposed in the Congress. This provision gives no consideration to the medical needs of the patient. It has been labeled, an economy measure, but, I submit, it is a false economy. It could have either of two results; the States would be forced to bear the additional costs, or patients would be prematurely discharged with a resultant threat to their health. We would respectfully suggest, Mr. Chairman, that this is an unfair provision, especially when you consider that the States were encouraged to join the Federal Government in a partnership to move ahead in an effort to provide health services to the medically needy.

In behalf of the members of the New Jersey Nursing Home Association, we urge this distinguished committee to eliminate section 225 from H.R. 17550 before the bill is reported to the Senate floor.

We are told from press reports and from other sources that the administration intends to submit a new health services program early next year, which will be intended to serve as a substitute for the present medicaid program. We are also aware of other efforts and movements to establish a national and comprehensive health insurance program. In consideration of these important factors, we would strongly urge, in behalf of those entitled to benefits under the medicaid program, and in behalf of the providers of health care services, that the Congress delay making a major reduction in benefits that would result from section 225.

Mr. Chairman, and members of the committee, I thank you for the opportunity to present these views. If you have any questions, I will be glad to try and answer them.

The CHAIRMAN. Does your colleague have a statement to make also?

STATEMENT OF REV. CLAUDE L. ROE, ASSISTANT DIRECTOR, THE PRESBYTERIAN HOMES OF THE SYNOD OF NEW JERSEY; TREASURER, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Reverend ROE. Yes, I am Claude L. Roe, past president of the New Jersey Association of Homes for the Aging, assistant director of Presbyterian Homes of New Jersey, and treasurer of the American Association of Homes for the Aging.

Mr. Chairman, and members of the committee, I am pleased to appear and testify before you today on H.R. 17550. The bill has many commendable provisions for improving the health care programs for the aged contained in the Social Security Act.

However, H.R. 17550 has among its provisions a section which threatens to fix into law a fundamental error which woulld obstruct rather than improve the ability of these programs to provide quality care in an efficient and economical manner. I refer here to section 225(a) and section 225(b). It is the opinion of many of us in the field that section 225(b) is an even more grievous error than is section 225(a).

Taken together, these provisions would fix into law the concepts that the norm for length of stay can be based upon the definition of a facility and that the costs of providing care and services can also be based upon the definition of a facility. These erroneous concepts would seem to be derived from equating the definition of a facility with the definition of a broad category of care and then, somehow making the potential care and services which the facility is equipped to provide become the actual care and services provided by the facility to an individual patient.

The reality is that a skilled nursing home is or should be equipped to provide skilled professional care and services, short of acute hospital care and services, for a host of patients each of whom requires such care and services but each of whom requires such care and serv-

ices in varying kinds, degree and amounts. It is the sum of the kinds, degree and amounts of care and services required by the individual patient and actually provided to the individual patient which determines the cost of providing such care and services.

Just as the care and services vary from individual patient to individual patient, so does the cost of providing care and services vary, even though in each instance the setting is the same and the category of care is the same.

The cost for each patient is different even where the broad category of the condition of two patients is the same. For example, the cost of a tonsillectomy will differ from that of an appendectomy. However, it is not unusual for the cost of a tonsillectomy for one patient to differ from the cost of a tonsillectomy for another. The decisive factors are the patient and his condition. What is true of the care and services provided by a hospital is equally true of the care and services provided by a skilled nursing home as well as for those provided by an intermediate care facility.

Therefore, I urge this committee to strike both section 225(b) and section 225(a) from H.R. 17550. I further urge you to treat skilled nursing homes under title XIX and intermediate care facilities under title XI in the same manner in which hospitals are treated under title XIX, namely, that the provisions of section 1902(a)(13)(D) of the Social Security Act as amended by section 229 of H.R. 17550 should be made applicable to title XIX skilled nursing homes and to title XI intermediate care facilities, that is, that States should be required to pay the reasonable costs of the care and services actually provided by the facility to the patient.

The factors which determine the proper length of stay for an individual patient. Therefore, again, I urge the committee to strike section 225(a) as well as section 225(b) from H.R. 17550. Mr. Chairman, I thank you for this opportunity to testify here today.

The CHAIRMAN. Thank you very much, gentlemen.

Thank you.

Now we will call Dr. William S. Day and Dr. Hoyt T. Duke, one president of the International Chiropractors Association and the other president of the American Chiropractic Association.

Senator TALMADGE. Mr. Chairman, it is a pleasure indeed for me to welcome to the committee my friend and constituent, Dr. Hoyt Duke of Augusta, Ga., who is president of the American Chiropractic Association.

STATEMENTS OF DR. WILLIAM S. DAY, PRESIDENT, INTERNATIONAL CHIROPRACTORS ASSOCIATION, AND DR. HOYT DUKE, PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION; ACCOMPANIED BY JOSEPH P. ADAMS, ICA COUNSEL; HARRY N. ROSENFIELD, WASHINGTON COUNSEL, AMERICAN CHIROPRACTIC ASSOCIATION; AND E. PAUL BARNHART, CONSULTING ACTUARY

Dr. DAY. Mr. Chairman, distinguished members of the Senate Finance Committee, I have a detailed statement which I would like to file for the record and summarize orally at this time.

My name is William S. Day, I am a practicing chiropractor in Spokane, Wash. I testify as president of the International Chiro-

practors Association. I am also a member of the senate of the Washington State Legislature and chairman of its committee on medicine, dentistry, drugs, public health, air and water pollution, and also serve as chairman of the legislative council's committee on public health and welfare.

I am accompanied by top ICA officers: Dr. John Q. Thaxton, of New Mexico; Dr. Grady V. Lake, of Atlanta; Dr. Marvin F. Klaes, of Seymour, Ind.; and our counsel from Washington, D.C., Brig. Gen. Joseph P. Adams. I join Dr. Duke, president of the American Chiropractic Association, in urging you to amend title XVIII of the Social Security Act to include chiropractic services in medicare, part B.

In enacting medicare, the Congress sought to protect our system of federalism by a "Prohibition Against Any Federal Interference": Section 1801. And yet, this guarantee is vitiated in title XVIII of the act.

As you know, 48 States, Puerto Rico, and the District of Columbia recognize and license the practice of chiropractics. Therefore, the Federal medicare law, by denying coverage of chiropractic services, penalizes the citizens of these 48 States and interferes with the operation of such State laws within the respective State boundaries.

Such Federal interference with States under medicare is all the more unjustifiable in the light of coverage of chiropractic services today under medicaid.

Therefore, we have the following strange results under the present law:

1. The medically indigent can obtain chiropractic services under medicaid.

2. But the medically self-sufficient, who voluntarily pay monthly insurance premiums, cannot obtain chiropractic services under medicare.

I respectfully suggest that this is an unwarranted Federal intrusion upon the States and that it is bad law.

The present law also flies in the face of section 1802 of the act. The law guarantees the patient freedom of choice to obtain health services from any qualified institution, agency, or person. Despite this assurance, America's self-supporting elderly are denied effective freedom of choice to obtain the needed and beneficial health services of State-licensed chiropractors.

Gentlemen, as a State legislator, I urge you to rectify this improper exclusion. We thoroughly agree with the Federal Social and Rehabilitation Administrator (HEW) John Twiname, who on June 5 of this year said:

> The right to free choice among providers is another step toward a single quality of medical care for all Americans, rich or poor.

Attached hereto is the full text of HEW-Z18, dated June 5, 1970.

Some of the best ways for the Congress to assure freedom of choice within medicare is to permit the people in the various States to use chiropractors to the extent and for the distinct and separate purposes permitted by State law. Anything else is a breach of fundamental Federal-State relations and a de facto Federal "takeover" of the licensing of allied health professions.

As a State legislator, I am of course sensitive and alert to the activities of State agencies. Reliable evidence of the effectiveness of chiro-

practic services is to be found in today's operations of State workmen's compensation programs. This experience seems to prove three things concerning chiropractic care:

1. Injured workers who use chiropractic care get well quicker and lose less wages because of illness of the same kind and severity for which others turn to medical treatment.

2. Employers find that chiropractic care brings their injured workers back to the job more rapidly. Thus, industry suffers less loss of productivity and earns lower compensation rates.

3. The States profit from chiropractic care in compensation cases, through lower State costs, increased tax revenues through increased productivity, and lesser calls upon State funds to supplement the reduced income of injured workers' families.

In closing, I would make an urgent plea not only on behalf of the chiropractic profession, but for the senior citizens that have learned through experience that chiropractic services are indispensable in the care of their health problems and then find themselves in the frustrating position of trying to pay for these necessary services out of their limited retirement income.

We believe that State-licensed practice has sufficiently proved the wisdom and feasibility of chiropractic as a valuable part of our Nation's system of health care. Consequently, there is no need for the further study specified in section 263 of H.R. 17550.

In its stead, we urge substitution of the identical provision of S. 1812, or S. 746, or section 201 of S. 2424, which have been introduced by distinguished members of this committee.

Thank you very much, Mr. Chairman.

(Mr. Day's prepared statement with attachment referred to follows:)

STATEMENT OF DR. WILLIAM S. DAY, PRESIDENT, *International Chiropractors Association*

SUMMARY

Recommendation.—Chiropractic should be included in Medicare, Part B, by the substitution of S. 1812, or S. 746, or § 201 of S. 2424 for § 263 of H.R. 17550.

1. *Prohibition Against Federal Interference* assured by § 1801 requires inclusion of chiropractic in Part B.

2. *Freedom of Choice*, guaranteed by § 1802, means the patient's Freedom of Choice in Medicare to obtain the services of State-licensed chiropractors.

3. *State Workmen's Compensation Programs* prove that chiropractic care gets injured employees back on job quicker, thereby saving wages and productivity and assuring higher State tax revenues and reduced State costs.

4. *No Further Government Studies Are Necessary.* Chiropractic has been proved by State-licensed practice over the years.

STATEMENT

My name is William S. Day and I am a practicing chiropractor in Spokane, Washington. I testify as President of the International Chiropractors Association. I am also a member of the Senate of the Washington State Legislature and Chairman of its Committee on Medicine, Dentistry, Drugs, Public Health, Air and Water Pollution, and also serve as Chairman of the Legislative Council's Committee on Public Health and Welfare. I am accompanied by top ICA officers Dr. John Q. Thaxton, Dr. Grady V. Lake, Dr. Marvin K. Klaes, and Gen. Joseph P. Adams, our Counsel.

Mr. Chairman, this is the first time that both the American Chiropractic Association and the International Chiropractics Association have appeared jointly before a Senate committee in a joint and unified presentation. I join Dr. Duke in urging you to amend Title XVIII of the Social Security Act to include chiro-

practic services in Medicare, Part B. As a State legislator, and speaking for what I know to be the reaction of virtually all State Governments, I believe that such an arrangement is wise and that it conserves and preserves the time-tested genius of this Nation's Federal-State system.

PROHIBITION AGAINST FEDERAL INTERFERENCE

In enacting Medicare, the Congress sought to protect our system of Federalism. The very first section of Title XVIII is entitled "Prohibition Against Any Federal Interference", Section 1801. And yet, this guarantee is vitiated through interference with States' freedom effectively to make available to their elderly citizens the health services of chiropractors.

As you know, 48 States, Puerto Rico and the District of Columbia recognize and license the practice of chiropractic. Therefore, the Federal Medicare law, by denying coverage of chiropractic services, penalizes the citizens of these States and interferes with the operation of such State laws within the respective State boundaries.

Such Federal interference with the States under Medicare (Title XVIII) is all the more unjustifiable because of the non-interference (and the consequent allowance of coverage of chiropractic services) under Medicaid (Title XIX). Thus, of the States which have adopted Medcaid legislation, some 17 already authorize chiropractic services.

Therefore, we have the following strange results under the present law:

1. The medically indigent *can* obtain chiropractic services under Medicaid (Title XIX).
2. But the medically self-sufficient, who voluntarily pay insurance premiums, *cannot* obtain chiropractic services under Medicare (Title XVIII).

I respectfully suggest that this is an unwarranted Federal intrusion upon the States, that it is bad law, and that it prohibits the Medicare beneficiaries from obtaining needed chiropractic health care.

FREEDOM OF CHOICE

This brings me to my second point, that the present law flies in the face of Section 1802 of the Social Security Act, "Free Choice by Patient Guaranteed". The law guarantees the patient's freedom of choice to obtain health services from any qualified institution, agency or person. Despite this assurance, America's self-supporting elderly are denied effective freedom of choice to obtain the needed and beneficial health services of State-licensed chiropractors. When such freedom of choice is denied, Medicare not only denies older people the health protection they want and need, but it also affronts the independence and dignity which Medicare is designed to assure. This fact involves not only fundamental theories of the relation between the Federal and the State governments and the relation between the American citizen and his government, but also the individual health, comfort and well-being of each and every Senior Citizen.

Gentlemen, as a State Legislator, I urge you to rectify this improper exclusion. We thoroughly agree with the Federal Social and Rehabilitation Administrator (HEW) John Twiname, who on June 5th of this year said: "The right to free choice among providers is another step toward single quality of medical care for all Americans, rich or poor." Attached hereto is the full text of HEW-Z18, dated June 5, 1970. Forty-eight States license doctors of chiropractic because their legislatures and Governors believe that chiropractic helps their people to maintain and regain their health. Many people around this broad land are beginning to wonder whether the Federal Government is trying to "take over" from the States the licensing of doctors, dentists, chiropractors and other health services. I am sure that the Congress will not permit this, but but I am equally sure that one of the best ways for the Congress to preserve Federalism within Medicare is to permit the people in the various States to use chiropractors to the extent and for the purposes permitted by State law. Anything else is a breach of fundamental Federal-State relations and a *de facto* Federal "take-over" of the licensing of allied health professions.

VALUE OF CHIROPRACTIC SERVICES

Third, as a State Legislator, I am of course sensitive to the activities of State agencies in my own State and elsewhere in the Nation. One of the most unbiased and reliable criteria of the effectiveness of chiropractic services is to be found

in the operations of State workmen's compensation programs which include chiropractic benefits. This experience seems to prove three things about chiropractic:

1. Injured workers who use chiropractic care get well quicker and lose less wages because of illness of the same kind and severity for which others turn to medical treatment.

2. Employers find that chiropractic care brings their injured workers back to the job more rapidly. Thus, industry suffers less loss of productivity and earns lower compensation rates.

3. The States profit from chiropractic care in compensation cases, through lower State costs, increased tax revenues through increased productivity, and lesser calls upon State funds to supplement the reduced income of injured workers' families.

Thus, everyone wins when chiropractors are permitted to serve the needs of people who want their services. That's why the States license them and pay for their services in workmen's compensation.

That's why I urgently recommend to you that this Committee should favorably report out a bill which includes chiropractic in Medicare. We believe that State-licensed practice has sufficiently proved the wisdom and feasibility of chiropractic as a valuable part of our national system of health care. Consequently, there is no need for the further study specified in §263 of H.R. 17550. In its stead, we urge substitution of the identical provisions of S. 1812, or S. 746, or S. 201 of S. 242 which have been introduced by distinguished members of this Committee.

Attachment A

U.S. DEPARTMENT OF HEALTH EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
OFFICE OF PUBLIC AFFAIRS,
Washington, D.C. June 5, 1970.

Freedom to choose among physicians, pharmacists, hospitals, nursing homes, and other prividers of medical services is now the right of patients whose medical bills are paid by Medicaid.

Any individual eligible for Medicaid may obtain the services covered by his State's Medicaid program from any qualified institution, agency, pharmacy, or practitioner participating in the program. Included are organizations offering medical services on a prepaid or membership basis.

"The right to free choice among providers is another step toward a single quality of medical care for all Americans, rich or poor," said Federal Social and Rehabilitation Administrator John Twiname.

Medicaid, now in operation in 52 U.S. jurisdictions, provides medical assistance for more than 12 million needy and low-income individuals who are aged, blind, disabled, or members of families with at least one parent dead, absent, or incapacitated. Certain other needy families are included in many States. About half the total cost is borne by the Federal Government and the balance by State and local government.

Puerto Rico, Guam, and the Virgin Islands, where most medical services are provided under Federal auspices, are not required to grant freedom of choice to Medicaid patients until 1972. The freedom of choice requirement, one of the 1967 amendments to the Medicaid law (Title XIX of the Social Security Act) became effective elsewhere July, 1, 1969, and is incorporated into the Code of Federal Regulations by publication in today's *Federal Register*.

The CHAIRMAN. Let me ask you a question about chiropractic. If a person has cancer, do you believe that chiropractic can do anything to help him with his cancer? Is there anything in chiropractic that can help him with his cancer?

Dr. DAY. No. I think that if a person possibly has a spinal condition then a chiropractor can help just the same as, I think, a dentist can help a person with his dental problem who also has a visceral condition.

The CHAIRMAN. I have heard doctors who are not all in agreement with your association, I am being the devil's advocate for the moment because I want to hear your argument on this thing——

Dr. DAY. Right.

The CHAIRMAN. I have had doctors tell me of situations where a person went to a chiropractor and the fellow pushed and tugged around on his spine and put him through some movements of one sort and another, and over a period of time it turned out that the man had, perhaps, cancer of the spine. Now if he did, he shouldn't have been with a chiropractor but should have been with someone else.

Dr. DAY. A responsible chiropractor, Mr. Chairman, should have referred him to someone else. We stand for the responsible position here and we recognize chiropractors are limited in their area of practice usually in most States to the spine and as it relates to the nervous system, and when we examine a patient who needs other care, whether it be dental, medical, podiatry, we refer promptly to other professions.

The CHAIRMAN. Well now is a chiropractor qualified to diagnose cancer?

Dr. DAY. A chiropractor is qualified in the area of differential diagnosis, and it is taught quite completely in our schools at the present time.

Now, if he recognizes any condition, cancer or any other condition, as I said, which needs referral, it is his responsibility to refer and he does make such referrals.

The CHAIRMAN. Well, suppose it is cancer of the blood, does a chiropractor have any competence to diagnose it?

Dr. DAY. A chiropractor wouldn't attempt to diagnose cancer of the blood any more than a podiatrist who was examining a foot problem would diagnose cancer of the blood. A chiropractor is confined to the spine and its misalinement as it relates to the nervous system. A chiropractor who goes beyond that and attempts to treat such a thing as a visceral cancer or any type of a malignancy is outside of his scope of practice.

The CHAIRMAN. Are there quite a number of other ailments other than cancer which are outside the competence of a chiropractor?

Dr. DAY. I would say definitely, yes.

The CHAIRMAN. Would you name some?

Dr. DAY. Fractures, pathological systemic conditions, conditions that require medications, drugs or surgery. A chiropractor is principally confined in his practice to the spine and its misalinement as it relates to the nervous system.

Now the involvement of people thinking that we apply to everything is that Gray's Anatomy says that the nervous system is the master system of the body which controls and coordinates all other systems. For example it is possible to have a cervical condition that affects the arms, fingers or shoulder.

The CHAIRMAN. We have reports that chiropractors are trying to treat those kinds of ailments.

Dr. DAY. We also have had reports like that. We have both chiropractic and medical disciplinary boards where the chiropractic board is empowered to stop those practices which are illegal.

The CHAIRMAN. Let me give you an illustration of the kind of thing I am thinking of.

This year my mother died of cancer. If she had gone to a doctor when the first sign of that cancer appeared, it is my judgment, and the judgment of my brother-in-law, who is a retired doctor, that the chances are very good she would be alive and happy with us today.

Now, that is our fault because we didn't push her into a doctor's office to overcome her reluctance to go to a doctor to determine whether that first indication might be a sign of cancer.

If we had sent her to a chiropractor and he had led her to believe he could help her with this, every valuable moment that could have been used to advance the day and the time when she would be accorded whatever treatment medical science can provide for that cancer would have been lost. It would be a great disservice to her for us to pay for something that is not doing her the least bit of good. In fact, we are wasting the time that may be precious to save her life.

Now, what would you suggest with regard to a chiropractor who would contend he would be able to help with this kind of a situation?

Dr. DAY. I would suggest if she had come into my office and we would have been able to ascertain her problem—and, of course, these problems are quite obscure even to the medical profession at times—we would have immediately urged her to have proper medical care, which may have accomplished the purposes that you wished be accomplished, Mr. Chairman.

I just feel that a chiropractor is quite competent in his area of practice, as are the other allied healing arts. There are many other allied healing arts, such as optometry, podiatry which are good examples.

The CHAIRMAN. Here is the argument that the medicaid profession makes against your profession, let's just lay it on the line, because I want to hear your answer to theirs. I don't think we would have much of a record here if we don't hear both sides of the argument.

Now, the medical profession says that your profession claims that it can treat all sorts of things for which it can do no good whatever, that the time that is spent is time wasted, and that in some cases there is a risk to the person's life.

Here is an HEW report on the things that they have severe doubts that a chiropractor can do much about, some of which I am sure you would contend he can do something about. Here is the percentage of chiropractors that they say are reporting to be treating these conditions: headaches. I take it that you contend that a chiropractor can help a headache.

Dr. DAY. First, let me state categorically that the chiropractor does not claim to be able to cure all conditions. Now as to certain types of headaches. In fact we are very successful on many types of headaches.

The CHAIRMAN. How about migraine?

Dr. DAY. Migraine?

The CHAIRMAN. Yes.

Dr. DAY. No.

The CHAIRMAN. All right.

Well, this reports that 98 percent of chiropractors are treating headaches. You say they can help with some.

How about sinusitis?

Dr. DAY. Only if this condition emanates from interference with nerve function in the spine.

There is more than one cause for some of these conditions or symptoms or effects that we are talking about, and when the primary cause is in the spine, that is when chiropractic applies.

The CHAIRMAN. High blood pressure.

Dr. DAY. There again, if it is diseased blood vessels and the lumens are narrowed, that is, arteriosclerosis, chiropractic certainly does not apply. If it is due to hypertension produced by interference with nerve functions or spinal misalignments, absolutely yes.

The CHAIRMAN. Asthma.

Dr. DAY. Asthma is a constriction of the bronchial system and the nervous system controls the musculature of the body. I personally have had excellent results with asthma, particularly in children.

The CHAIRMAN. Hay Fever.

Dr. DAY. Yes. A chiropractor gets good results on hay fever.

We are dealing with an HEW report from a panel which had no chiropractor on it. In other words, this is a report made by people who had really very little, if any, knowledge of chiropractic.

The CHAIRMAN. All right. Ulcers, can you help an ulcer by tugging on the spine?

Dr. DAY. Of course we don't tug on the spine.

The CHAIRMAN. Or push on it?

Dr. DAY. Well, specific adjustment which removes interference to the nerve function can restore function and that is all the chiropractor does. We do not treat ulcers.

The CHAIRMAN. You don't treat ulcers?

Dr. DAY. No, sir.

The CHAIRMAN. Well, this report says 76 percent of chiropractors report they are treating ulcers.

Now, this is Health, Education, and Welfare reporting to us. How about deficient——

Dr. DAY. I don't know where they got those figures, Senator.

The CHAIRMAN. This is a figure that is given to us—let me just ask you and get your answer to it. This is a report given to us by HEW. Deficiency anemia. Can you do anything for anemia?

Dr. DAY. Pernicious anemia?

The CHAIRMAN. Deficiency anemia.

Dr. DAY. It would depend upon the cause factor again. You can read "Hughes Practice of Medicine," and you can find under etiology, which is cause, the cause is obscure, cause unknown. Here again we are getting back onto an understanding of body physiology. Halliburton's Physiology, which is not a chiropractic text, but a standard text, enumerates all the systems, blood, vascular, respiratory, circulatory, muscular skeletal, and says over and above all of these is the nervous system, the great master system of the body.

Chiropractic is a breakthrough in a new healing art which recognizes and understands a relationship between nervous control of body physiology and the other systems. Again, we apply our correction to the spine and its misalinements as they relate to the nervous system. This does have a new approach rather than trying to stimulate body function or change body chemistry by chemotherapy or by drugs.

The CHAIRMAN. Well now if a man comes in and he has anemia I would take it you would try your technique and see if it would help?

Dr. DAY. No, Senator. What we would do, if a man came into my office, I would take a complete case history of him. I would examine his spine using instruments and X-ray to determine if there was any evidence of nerve interference and remove that nerve interference if

there were any. We would not treat the medical condition you are referring to.

The CHAIRMAN. Do you believe that you can help a chronic heart condition?

Dr. DAY. No, sir. I believe that we cannot correct the pathology by a spinal adjustment where there is permanent damage, but it is certainly true that there is a neurological control of heart functions as there are of other functions.

The CHAIRMAN. Hemorrhoids.

Dr. DAY. Hemorrhoids are prolaxed veins. A muscle is maintained in tone by proper nerve supply. If this particular loss of tone was not due to damage, if it were due to loss of nerve supply, in fact we have had excellent results with some cases of external hemorrhoids by adjusting in the lower lumbar spine because there is a direct anatomical provable neurological connection.

The CHAIRMAN. What about hepatitis?

Dr. DAY. Hepatitis is an infectious disease. We would refer this to a physician.

The CHAIRMAN. According to this report, 32 percent of chiropractors reported treating hepatitis.

Pneumonia, do you think you could help with pneumonia?

Dr. DAY. Senator, this particular report you referred to again had 22 or 23 people on the committee. Twenty-two of them were either medical doctors or medically oriented. There was no chiropractor on the study committee. The special technical committee was made up of eight people, five of whom were medical doctors. So the report, I say, is an erroneous report.

The CHAIRMAN. Now, here—in this same report—it refers to a text: *Chiropractic Principles and Techniques, 1947, 11 Techniques for Tonsils—Indications.*—This technique is used when the tonsils are slightly inflammed. After sterilizing his finger, the doctor places his fingertip on the inflammed tonsils. He strokes downward using a slight pressure. The amount of pressure to be used is determined by the tolerance of the patient. Was that technique used by chiropractors?

Dr. DAY. No, Senator Long. That is a technique taken out of a book written by one individual which has never been accepted by any of the chiropractic educational institutions or either of the associations involved here in this national position.

The CHAIRMAN. Well, now, according to this report this was the second most widely used chiropractic textbook. In fact, it was written by Dr. Joseph Janse, president of the National College of Chiropractors and chairman of ACA's Commission on Standardization of Chiropractic Principles, and it was the second most widely used textbook.

Dr. DAY. I am a graduate of the largest chiropractic school in Davenport, Iowa, as my mother, father, brother, and son are, and I have never seen such a writing by Dr. Janse.

The CHAIRMAN. What would you think would happen if you massaged an inflammed tonsil?

Dr. DAY. I wouldn't have the slightest idea, Senator, because it certainly wouldn't be within the scope of my technique.

My technique is confined to the care of the spine as it relates to the nervous system, and, of course, this might be taken out of context or

something in relation to some technique but it is certainly not a chiropractic technique.

The CHAIRMAN. My thought is that insofar as you can convince me that you are doing somebody some good, I would be willing to cooperate but I am not inclined to cooperate when I am not convinced that you have. My feeling is that the only time a chiropractor worked on me it didn't do any good, so I guess I am prejudiced by that.

Dr. DAY. Mr. Chairman, chiropractic is like any other science, it requires proper application, and, of course, we are dealing with a variable in human life anyway. It is possible that the application wasn't correct or from some of the techniques you have talked about I hope they didn't use any of those on you if they called themselves chiropractors.

The CHAIRMAN. Thank you. Any further questions?

Senator TALMADGE. Dr. Day, what would be the cost of chiropractic services if they are added to title XVIII?

Dr. DAY. Well, we have had an actuarial study and we have the actuary with us and I would like to have him address himself to this question. We have a statement of fact involving 19 private companies that write over 44 percent of all the health insurance in existence.

Senator TALMADGE. Will you submit that for the record?

Dr. DAY. Yes, I will.* And it demonstrates clearly that there was no additional cost in their adding it.

Senator TALMADGE. What is the additional cost of the commercial company to include chiropractors?

Dr. DAY. No extra cost is what the commercial insurees found.

Senator TALMADGE. Your contention is it wouldn't cost anything?

Dr. DAY. That's right.

Senator TALMADGE. Thank you, Mr. Chairman.

Dr. DAY. Beause, you see, it is the conditions that are covered, not the individual services, and it is an elective to take chiropractic care in lieu of another care, and our care in the study done on workmen's compensation proves it is more effective where chiropractic applies and cuts down the time and the cost.

Mr. Barnhart, would you like to go into that?

Mr. BARNHART. Mr. Chairman, my name is E. Paul Barnhart. I am a Fellow of the Society of Actuaries and a consulting actuary with an office in St. Louis.

I have conducted a very thorough study of the estimated costs of chiropractic services under the medicare program, that is if they were to be included under the medicare program, and I hope that that entire study will be part of the record and available to your committee members.

I have estimated that under the medicare program if chiropractor services were included that the cost per person would be approximately 11 cents per month, the additional cost. This is a net figure that arises from certain areas of obvious increase in costs if chiropractic care were included, and also takes account of offsetting savings in other areas where chiropractic care could be utilized at less cost than alternative care by other practitioners.

The report is, I think, quite well documented and quite thoroughly layed out, and I believe your committee would be able to obtain all the information you would wish on this point from a study of that report.

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*See p. 584.

Mr. ROSENFIELD. May I comment that 11 percent is the total figure——

Senator TALMADGE. You don't mean 11 percent, you mean 11 cents.

Mr. ROSENFIELD. Yes, thank you Senator; 11 cents is the total figure, approximately only half of which is Federal contribution.

The CHAIRMAN. But suppose a person really doesn't think that chiropractic does him any good, why should he have to pay the 11 cents?

Dr. DAY. You are speaking of an individual person?

The CHAIRMAN. In the first place is not that a risk on which the patient could just as well be a self-insurer; that is just take his chance and pay for his chiropractic in the event that he needs it? Is not that type treatment a risk on which the average person could well be a self-insurer?

Dr. DAY. Mr. Chairman, that, of course, is what is happening at the present time and we have many elderly coming into my office at the present time asking why doesn't medicare cover this, "You give a service I cannot obtain anywhere else." There is no other profession that gives specific chiropractic adjustment to remove nerve interference, and they have found that this is the key to their health problems. They just say they are paying this insurance premium for their protection in their later years and they are entitled to have the type of care that they have found usually by trying the accepted orthodox methods first that didn't work and then turning to the chiropractic care. Chiropractic is a very basic thing that is based on scientific principles that work. Otherwise it wouldn't have withstood what we have withstood for 75 years.

The CHAIRMAN. Are you asking that chiropractors be included where they have tried other things and they didn't work?

Dr. DAY. No. We are asking that chiropractic be included on an equal free selection basis. We urge the freedom of choice—of course, there will be people who don't use chiropractic either through lack of knowledge or for lack of need of it.

Mr. ROSENFIELD. Mr. Chairman, I am not sure that we have specifically answered your question, and I think it ought to be answered. You asked: Why should a person pay for chiropractic if he doesn't want it? This is just as true of any portion of the existing part B of title XVIII, such as surgery. If a person doesn't use or doesn't want surgery he still pays his full contribution including that part which would be for surgery. Thus, non-use does not obviate the payment of premiums.

The real question is, as Dr. Day has indicated, whether the patient has the freedom of choice if, in his judgment, he thinks he wants a particular licensed benefit service.

The CHAIRMAN. Well, when a Christian Scientist is offered the program, he doesn't want a doctor, so he doesn't sign up for part B to begin with. He feels he doesn't believe in it as a religious matter and doesn't sign up. If a person wants a chiropractor it is perfectly all right with me if he wants to insure himself for those services.

Is it not true that there are a lot of people who are not at all convinced that chiropractic does them any good?

Dr. DAY. Usually they are people who have never had any experience with it or have had an experience such as yours.

The CHAIRMAN. Well, my experience didn't prove it did me any good at all, so naturally——

Dr. DAY. Of course, Senator, if we could get the problem corrected in your State so we could properly license and qualify chiropractors, maybe you would have gotten into a better place.

The CHAIRMAN. Now, the chiropractor would have been licensed if we passed the law, but can you tell me why, by-passing an act of legislation he would have done a better job than he did?

Dr. DAY. No; he wouldn't. Maybe he was not a properly qualified man.

The CHAIRMAN. I think he was properly qualified. He did the best he could do.

Did you ever have the experience of working on somebody you failed to do any good for.

Dr. DAY. I know of many.

The CHAIRMAN. I know as a lawyer there were occasions when my client was not any better off when he left than when he showed up. As a doctor you might have had the same experience.

Dr. DAY. Yes.

Mr. BARNHART. Mr. Chairman, I would like to offer one other comment about this matter of the 11 cent cost. This, of course, is the total cost of which the individual is paying for part B will be paying half or only five and a half cents. But the point I want to make is that part of the reason for this 11 cents increase in cost is that there are quite a few small town and rural areas in the country where the only professional man available is a chiropractor. Some of these small town and rural areas do not have any other practioner available locally to care for the people. So if elderly people who live in these areas are not able to obtain chiropractic care under the medicare program, the practical effect is that no care is available to them at all. And part of the reason why I have cocnluded that there would be this net increase in total cost of 11 cents is specifically due to this situation.

The CHAIRMAN. Well, gentlemen, your case is in better shape than it was when you arrived, I will assure you of that.

Dr. DAY. Thank you.

Senator ANDERSON. In the audience today is Dr. Thaxton of New Mexico, my staunch friend and I have know him over a great many years. I am glad to see he is here today.

The CHAIRMAN. Thank you very much.

Dr. DAY. There is another doctor with a short statement.

Dr. DUKE. Mr. Chairman and gentlemen, with your permission I should like to file my statement for the record and briefly summarize it orally.

I am Hoyt B. Duke, a practicing doctor of chiropractic from Augusta, Ga. As President of the American Chropractic Association, I am delighted to participate in a unified presentation on behalf of the entire chiropractic profession of the United States. I am accompanied by Dr. G. M. Brassard of Beaumont, Tex.; Dr. Robert L. Thatcher of St. Paul, Minn.; Mr. E. Paul Barnhart, whom you have met already, a consulting actuary of St. Louis; and our Washington counsel, Mr. Harry N. Rosenfield.

We appear before you to urge the inclusion of chiropractic services in medicare, to the extent that such services are authorized by State

law, just as you have long included chiropractic in the medicaid program. In particular, we urge you to delete section 263 of H.R. 17550 and substitute in its place S. 1812, or S. 746, or section 201 of S. 2424, identical bills introduced by distinguished members of this committee.

Chiropractic services are of special importance to senior citizens. According to the National Center for Health Statistics, almost twice as many people in the pre-medicare age (45–64 years of age) receive chiropractic services as do the population as a whole. And this use of chiropractic by elderly patients has been increasing to an even higher percentage.

One-third of all conditions causing activity limitations to persons 65 years of age and older were due to musculo-skeletal impairment. Among the general practitioners of the healing arts, doctors of chiropractic are better qualified by education and experience in the detection and correction of neuro-musculo-skeletal conditions and their effects. Congress and the Government of the United States have officially recognized chiropractic in:

Medicaid;

Federal Civil Service and Federal employee health benefit plans; and

Income tax, among other laws.

Chiropractic has been officially recognized as a health profession in 48 States. Each State has specific laws defining the practice of chiropractic, prescribing requirements for licensure and authorizing chiropractic services and care. In addition, claims for chiropractic care are paid by workmen's compensation in 48 States.

Many hundreds of commercial insurance companies (including most of the private carriers which administer medicare) include chiropractic in their commercial health and accident policies.

I should like, very briefly, to outline some of the grassroots demands among Americans in all parts of the country for chiropractic coverage in Medicare:

SENIOR CITIZENS

Organizations representing multiple millions of senior citizens have asked for such coverage. These include the largest retiree organization in the United States, the National Retired Teachers Association-American Association of Retired Persons; and also others such as the National Association of Retired Civil Employees; various statewide and local senior citizen organizations; UAW retiree groups; and various nationality groups such as the Polish American senior citizens.

ORGANIZED LABOR

International, State and local union organizations representing more than 8½ million trade unionists have asked for chiropractic coverage in medicare.

VETERANS

Demands for chiropractic benefits in medicare have been expressed by major national veterans organizations such as VFW, AMVETS, veterans of World War I, and by State departments and local posts of other organizations.

And lastly, I wish to report on an actuarial study made by a distinguished independent actuary, E. P. Barnhart, on the cost of chiro-

practic inclusion in medicare. His full study is attached to my statement, and I respectfully ask that it be made part of the record. He is also present and has already answered a lot of your questions. But his report shows that:

(1) The total cost to the Federal Government for including chiropractic in part B would be only 5.5 cents per enrollee per month; and

(2) There was "no significant net change in costs" when 19 major health insurance companies "writing 44 percent of all commercial health insurance in the United States" expand their coverage to include chiropractic services.

In conclusion, may I express our thanks for the opportunity to testify. We urge you to include chiropractic services in the medicare program, as proposed by the identical S. 1812, S. 746, and section 201 of S. 2424 introduced by four distinguished members of this committee.

Thank you, Mr. Chairman, for letting us testify.

The CHAIRMAN. Well, thank you, gentlemen.

(Dr. Duke's prepared statement and an attachment referred to during Dr. Day's testimony, follows. A letter dated Sept. 30, 1970, received by the committee from Dr. Duke appears in the appendix, part 3. Hearing continues on page 603.)

DR. HOYT B. DUKE, PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION

SUMMARY

Recommendation.—Substitute S. 1812, or S. 746, or § 201 of S. 2424 for § 263 of H.R. 17550, so as to include chiropractic in Medicare, Part B.

1. *Chiropractic is a recognized health profession.*
2. *Chiropractic services are of special importance to Senior Citizens.*
3. *Chiropractic has been officially recognized by the Congress in medicaid, in Federal civil service, for Federal employee health programs, for income tax, and for other purposes.*
4. *Chiropractic is officially recognized and licensed by the State.*
5. *Senior Citizens are demanding chiropractic services in Medicare.*
6. *Major veterans groups have asked Congress to include chiropractic in Medicare.*
7. *Major portions of organized labor strongly support chiropractic in Medicare.*
8. *Chiropractic inclusion in Medicare would cost the Federal Government very little, if anything, extra.*

STATEMENT BY DR. HOYT B. DUKE, PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION, BEFORE THE COMMITTEE ON FINANCE, U.S. SENATE

(Wednesday, September 16, 1970)

I am Hoyt B. Duke, a practicing doctor of chiropractic from Augusta, Georgia. As President of the American Chiropractic Association, I am delighted to participate in a unified presentation on behalf of the entire chiropractic profession of the United States.

I am accompanied by Dr. G. M. Brassard, Past President; H. N. Rosenfield, our Counsel; and E. P. Barnhart, Consulting Actuary.

We appear before you to urge the inclusion of chiropractic services in Medicare, Part B, to the extent that such services are authorized by state law, just as you have long included chiropractic in the medicaid program. In particular, we refer to three bills introduced by distinguished members of this Committee, S. 1812, S. 746, and S. 2424 (Sec. 201). These bills are virtually identical with what the Senate has twice previously passed, and we urge that you substitute their provisions for the wholly unnecessary Sec. 263 or H.R. 17550.

Chiropractic

Chiropractic is a study of health and disease from a structural point of view with special consideration given to spinal mechanisms and neurological relations. Chiropractic is the largest drugless healing profession. It does not include the practice of surgery.

Doctors of chiropractic have been classified by the United States Public Health Service, in a 1966 study, as among "medical specialists and practitioners" including pediatricians, obstetricians and opthalmologists, among others. The PHS's *Health Manpower Source Book* includes doctors of chiropractic along with physicians, surgeons and dentists.

Health Needs

The National Health Survey, conducted some 10 years ago, showed that of all the people in the United States with permanent impairments, 19 percent suffered from chronic impairment of the back or spine.[1] At today's population figures, this amounts to some 5,400,000 people.

In addition, the National Safety Council reports that "about 400,000 workers suffer disabling back injuries each year, and the number seems to be increasing faster than injuries in general * * *[2]

Chiropractic services are of special importance to senior citizens. According to the National Center for Health Statistics, almost twice as many people in the pre-medicare age (45–64 years of age) receive chiropractic services as does the population as a whole.[3] And this use of chiropractic by elderly patients has been increasing to an even higher percentage.[4]

Another Public Health Service report shows that one-third of all conditions causing activity limitations to persons 65 years of age and older were due to musculo-skeletal impairment.[5] Among the general practitioners of the healing arts, doctors of chiropractic are better qualified by education and experience in the detection and correction of neuro-musculo-skeletal conditions and their effects, and in the referral of such patients where non-chiropractic methods of care would be more effective or necessary.

Official Status

Federal.—The Congress and the Government of the United States have officially recognized chiropractic as follows:

1. *Medicaid* authorizes chiropractic services under Title XIX.
2. *Federal Civil Service* accepts chiropractic statements for sick leave of Federal employees and authorizes chiropractic services in Federal employee health programs.
3. *Income Tax* permits medical deductions for chiropractic health care.
4. *Immigration* recognizes chiropractic colleges as a basis for student status of aliens.
5. *The District of Columbia*, by Act of Congress, licenses doctors of chiropractic.

State.—Chiropractic has been officially recognized as a health profession in 48 states. Each state has specific laws defining the practice of chiropractic, prescribing requirements for licensure, and authorizing chiropractic services and care.

In addition, claims for chiropractic care are paid by: (1) workmen's compensation, in 48 states; and (2) medicaid, in some 17 states.

Insurance Payments

Many hundreds of commercial insurance companies (including most of the private carriers which administer medicare) include chiropractic in their health and accident policies.

And 19 states already have enacted "insurance equality laws" which, generally speaking, require the reimbursement of licensed doctors of chiropractic whenever the insurance policy provides for a health service which may legally be provided by a doctor of chiropractic in that state.[6] This legislation involves 75 million Americans with health and accident policies issued by private insurance companies. In addition, we understand that some 4 states have such equality laws applicable to Blue Shield.[7] I should also add that Blue Cross pays for chiropractic services in Ontario, Canada.

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[1] "Selected Impairments by Etiology and Activity Limitations," July 1959–June 1969, National Health Survey, Series B, No. 35, p. 22 (July 1962).
[2] National Safety Council. *Accident Facts* (1967 edition), p. 31.
[3] National Center for Health Statistics, Series 10, No. 28, p. 37.
[4] Higley, H. G., "Patients Past 65 Under Medi-Cal" (1968, unpublished).
[5] National Center for Health Statistics, Series 10, No. 32, p. 65.
[6] These states are: California, Connecticut, Delaware, Illinois, Indiana, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, Ohio, Rhode Island, South Dakota, Utah, and Virginia.
[7] The states are: Connecticut, Indiana, Massachusetts, and Nebraska.

Demand for Chiropractic Services

I should like very briefly to outline some of the grass-roots demands by senior citizen groups, organized labor and by veterans groups for chiropractic coverage in medicare:

I. *Senior Citizens.*—Senior citizens all over this nation are disturbed by their present inability to obtain chiropractic services in Medicare. As evidence of this demand, I call to your attention the following:

1. a resolution by America's largest organization of retired persons, the National Retired Teachers Association—American Association of Retired People, for "inclusion of chiropractic services under Part B of Medicare";
2. similar views of the National Association of Retired Civil Employees;
3. resolutions by statewide senior citizens organizations in Arkansas, Florida, Oregon, Texas, and Wisconsin, and by many local organizations in other states, asking for chiropractic inclusion in Medicare;
4. similar views by various UAW Retiree groups; and
5. similar resolutions are policies by various national ethnic groups such as the Polish-American Senior Citizens.

II. *Organized Labor.*—A substantial number of international unions, state labor federations, municipal central labor bodies and regional, districts and local unions embracing more than 8½ million trade unionists have gone on record in the past two years for chiropractic inclusion in Medicare. The Teamsters Union has strongly urged chiropractic coverage in Medicare. The same is true of some of the largest state AFL-CIO affiliates, such as New York, Pennsylvania, Illinois, New Jersey and Texas. In addition, similar actions have been taken by state federations in Arkansas, Florida, Georgia, Oregon and Washington State.

In addition, many local unions have adopted resolutions demanding chiropractic services in Medicare. Recently two of the largest districts of the steel workers did so, as have unions of auto workers; transit workers; Federal employees; state, county and municipal employees; painters; milk drivers; longshoremen; retail clerks; and organizations of policemen and firemen.

You will also be interested to know that the International Longshoremen's Association has requested chiropractic coverage in Federal health programs operated for its union members.

But even more than resolutions is the operation of union health and welfare funds negotiated by trade unions precisely to include chiropractic. For example, the state, county and municipal workers, and dozens of other unions that have contracts with the City of New York (with more than 230,000 members covered) have included chiropractic in their health insurance plan. The State of California has more than 100 separate union health and welfare programs with chiropractic coverage, ranging from such diverse industries as the motion picture community to meat cutters and longshoremen. The same situation prevails in New York. And a substantial number of large affiliates of the AFL-CIO, the Teamsters, United Auto Workers and major independent unions have some recognition and inclusion of chiropractic, ranging from International Union industry-wide contracts to those negotiated on a regional, district, state-wide or local union level.

Other unions, such as the Candy and Confectionary Workers Union and the Uniformed Sanitationmen's Union of New York City, have established their own chiropractic clinics as part of permanent health care centers for the use of their members. In operation for some three years, both clinics report satisfactory experience.

III. *Veterans Groups:*

1. *The Veterans of Foreign Wars,* at their 70th National Convention in August 1969, adopted Resolution No. 155 which states in part: "that we go on record as urging the Congress of the United States to amend the Social Security Act to cover our elder citizens and veterans needing chiropractic treatment for their various ailments."
2. *AMVETS,* at their national convention in August 1967, adopted Resolution No. 160 which states, in part: "do urge all members of Congress and the President of the United States to make chiropractic care and the services of chiropractic physicians available to all recipients of service under Medicare and medicaid . . ."
3. *The American Legion Departments* of Alabama, Oregon, South Carolina and Texas adopted resolutions asking inclusion of chiropractic in Medicare. Similar views have been expressed by resolutions adopted in local posts in Texas and Arkansas, among other states.

4. *The Veterans of World War 1*, at its annual convention in 1969, passed a resolution calling for chiropractic coverage by Medicare. These are only selected examples of veterans' demands for chiropractic services in Medicare.

Chiropractic Education

Chiropractic colleges require a minimum of four academic years of resident professional study, including clinical experience under strict supervision. Chiropractic colleges provide more hours of instruction than medical schools in the following six basic subjects:

1. anatomy
2. physiology
3. radiology
4. rehabilitation
5. nutrition
6. public health

In this connection, I submit for the Committee's files a copy of *Chiropractic's "White Paper"* which documents these educational data, and also provides the facts to deal with questions of diagnosis by doctors of chiropractic and the effectiveness of chiropractic services.

Actuarial Study

The American Chiropractic Association retained a distinguished consulting actuary, E. Paul Barnhart of St. Louis, Missouri, to make an independent study of the probable cost of chiropractic inclusion in Medicare. His study is attached to my statement and I respectfully request that it be included in the record. Mr. Barnhart found that:

> 1. the total cost of including chiropractic in Medicare would be 10.5 cents per enrollee per month, of which the Federal Government's share would be only 5.5 cents per enrollee per month; and
>
> 2. a survey of 19 major health insurance companies (which combined wrote 44% of all commercial health insurance in the U.S. in 1967) resulted in the conclusion "that *no significant net change* in costs resulted from their expansion of coverage to chiropractic services."

Mr. Barnhart is with us today and is available for questioning if the Committee wishes to do so.

I have already noted that the nation's largest association of retired persons, the National Retired Teachers Association-American Association of Retired Persons, which has over 2 million members, has approved chiropractic benefits in Medicare. These organizations provide health insurance to their own members through the Colonial Pen Life Insurance Company of Philadelphia, Pennsylvania. I attached hereto, and request that it be placed in the record, a letter of March 20, 1969, from that company to Dr. G. M. Brassard, last previous president of the American Chiropractic Association, stating:

> We have no extra charges attached to our contracts for the inclusion of chiropractors, if they are chosen by the patient.

In conclusion, may I express our thanks for the opportunity to testify. We urge that, instead of Sec. 263 of H.R. 17550, this Committee include chiropractic services in the Medicare program as proposed by S. 1812, S. 746, and Sec. 201 of S. 2424 which have been introduced by distinguished members of this Committee and are identical with what this Committee has twice previously reported favorably. We earnestly believe that this will be in the best interest of the American people.

ACTUARIAL STUDY

(Concerning the Cost of Including Chiropractic Services in Federal "Medicare," Prepared by E. Paul Barnhart, F.A.S., Consulting Actuary, August 1, 1969[1])

INTRODUCTION

The object of this actuarial study is to determine, so far as available facts and statistics permit, what probable amount, if any, would be added to the cost of Federal "Medicare" as a direct result of expanding that program to include the cost of chiropractic services. The estimates of this study relate to cost levels and Medicare enrolled population as of the current year—1969.

[1] This Study is a revision of an original study prepared in June 1968, and updates all cost estimates to the year 1969.

Only a limited amount of statistical information is available which has a direct and immediate bearing on the subject. To some extent it has been necessary to make use of information which is only of indirect assistance in finding the answers, and to draw conclusions as to the probable effects through inference. Nevertheless, it has been possible to arrive at such conclusions with a considerable degree of confidence, and these are presented in the concluding section of this report.

I. THE COMPARATIVE COST OF CHIROPRACTIC SERVICES IN RELATION TO THE SERVICES OF OTHER PRACTITIONERS

There appear to be only scattered sources of information on this important question, and some of the extent data are now several years old. Consequently, in order to gather a body of recent data on this subject, the American Chiropractic Association, in cooperation with the Iowa State Industrial Commission, conducted a survey of Workmen's Compensation claims incurred during the calendar year 1966. This survey was conducted under the direction of Dr. Louis O. Gearhart, D.C. (at that time Director of Professional Affairs of the American Chiropractic Association) with the benefit of my actuarial advice.

In order to confine the survey to a reasonably homogeneous group of injury cases, it was limited to cases classified as "back injuries" only. During 1966, there were a total of 2518 such claims filed with the Iowa Workmen's Compensation Service. These cases were classified according to whether treatment was rendered by a Doctor of Chiropractic (D.C.), on the one hand, or by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), on the other. The results are as follows:

Total number of cases classified as back injuries	2,518
Total number of cases treated by D.C., 14.5 percent	389
Total number of cases treated by M.D. or D.O., 84.6 percent	2,129
Average number of cases treated per month by:	
D.C.	32.4
M.D. or D.O.	177.4
Average work time loss per case under care of:	
D.C. (weeks)	2.64
M.D. or D.O. (weeks)	5.62
Average cost per case for treatment under care of:	
D.C.	$68.24
M.D. or D.O.	$118.74
Average cost per case for hospital charges under care of:	
*D.C.	$20.23
M.D. or D.O.	$121.98
Average cost per case for other charges (braces, supports, etc.):	
D.C.	$0.81
M.D. or D.O.	$4.18

*There is no inference intended to indicate treatment in hospitals by the D.C. Rather, some time in the history of the case (whether treated by the D.C. or others) there were hospital charges involved before the case was reported as closed by the Workmen's Compensation Service.

The average cost per case. where treatment was under the care of a D.C., was only 57.5% of the average cost when care was rendered by an M.D. or a D.O. ($68.24 vs. $118.74).

There is, of course, an obvious potential flaw in this comparison. It is possible that the claimants more commonly sought the care of D.C.'s in cases of minor back sprains and strains, whereas M.D.'s or D.O.'s were more commonly in attendance on cases of major injury involving surgery and hospitalization. From the Iowa records reviewed, it was not possible to subdivide further the category "back injuries" as to exact diagnosis and severity. It is known, however, that the great majority of such injuries are in fact sprains and strains, as may be readily verified from other sources. The following statistics are given in the study "Back Injuries: A Major Health Problem in the United States," compiled under the direction of Henry G. Higley.[2]

[2] "Back Injuries: A Major Health Problem in the United States" prepared by the Department of Research and Statistics, American Chiropractic Association; Henry G. Higley, M.A., D.C., Chairman. (Copyright, 196, American Chiropractic Association)

Lost Time Back Injury Claims filed in 1961 with the Industrial Commission of Ohio:

Contusions, bruises	1,806
Dislocations	3
Fractures	245
Lacerations	29
Sprains and Strains	11,505
All other	53
Total	13,641

(Sprains and strains comprised 84.3% of the total.)

Compensation Cases closed in 1963 by New York Workmen's Compensation Board:

Herniated Disc	1,397
Fractures and Dislocations	743
Strains and Sprains	14,899
All other	767
Total	17,806

(Sprains and strains comprised 83.7% of the total.)

Comparable data shown for the State of Washington (fiscal year 1963–64) indicate that sprains and strains accounted for 92.1% of 5,189 back injury claims filed.

Accordingly, we may conclude with certainty that the great majority of cases treated by both categories (D.C., and M.D.–D.O.) of practitioners in the survey of 1966 Iowa claims were sprains and strains of the back, and the average cost of such treatment was significantly lower where rendered by a D.C.

Similar comparative figures are given in another study[3] carried out several years ago for the Insurance Relations Committee of the Florida Chiropractic Association. This study, conducted in 1960, examined the records of claims filed i.. 1956 with the Florida Industrial Commission, and was specifically limited to 1?,666 individual cases of sprains and strains of the neck, spinal vertebrae and external back. The results were:

	Average per case treated by—	
	Chiropractors	Medical doctors
Total cost of treatment	$51	$65
Workdays lost	3	9
Number of treatments	9	6
Average cost per treatment	$5.67	$10.83

Average total cost of treatment, when rendered by a D.C., was 78.5% of the average total cost when treatment was rendered by an M.D. The average D.C. "per treatment" cost was only 52.3% of the M.D. average.

As mentioned above, the average total cost of treatment for D.C.'s in the Iowa survey was 57.5% of the average for M.D.'s and D.O.'s combined. This lower figure undoubtedly results in part from the inclusion of all forms of back injury cases in the Iowa survey. In the Florida survey, the cases studied were narrowly limited to sprains and strains of the neck, spinal vertebrae and external back. Accordingly, these cases were highly homogeneous in character, and since they were cases involving only sprains and strains, injuries involving major surgical correction and other complications were excluded. Accordingly, the Florida study compares the cost of chiropractic to other types of professional treatment with respect to narrowly homogeneous and similar injury cases. The cases in the Iowa study are less homogeneous, and, as one might well expect, the divergence in cost between chiropractic and other forms of treatment is greater (57.5% in the Iowa study, compared to 78.5% in the Florida study). Consequently, the Florida study must be regarded as a more reliable measure of the comparison under *equivalent* injury cases. This evidence would indicate that the average cost of

[3] "A Survey and Analysis of the Treatment of Sprain and Strain Injuries in Industrial Cases" prepared for the Insurance Relations Committee, Florida Chiropractic Association, April, 1960.

total treatment, when rendered by D.O.'s, may reasonably be assumed to run between 70% and 80% of the average cost for treatment of comparable conditions by M.D.'s and D.O.'s.

It is quite important to recognize that the comparative cost of treatment must be determined, for our purposes here, on the basis of *average total cost of treatment*, not on some other basis such as average charge for an office visit or even average cost per treatment. If the comparison is made on the basis of average charge for an *office visit*, too high a ratio will result. If the comparison is made on the basis of average cost *per treatment*, too low a ratio will result.

The reason for the latter is that the average *number* of treatments, per case, is higher for chiropractic care than for other professional care (9 vs. 6, in the Florida study). The reason for the former is that, when care is given by an M.D. or a D.O., the amount of *other* charges, in addition to the simple charge for an *office visit*, will be greater. These will involve such items as injections or other doctor-administered drugs, diagnostic x-ray and laboratory examinations, and, in some instances, surgery.

A study[4] made by Batten and Associates, in 1963, showed the usual charge by a chiropractor for a "routine office visit" to be $4.34. A "Fee Guide" published in 1962 by *Medical Economics* showed the similar charges, by general practitioners and internists, to be $4.25 and $5.75, respectively. Thus, if a comparison were drawn purely from such comparative charges as these, one might be drawn erroneously to the conclusion that the average cost of chiropractic care runs about 85% as high as when such care is rendered by a mixture of general practitioners and internists. As shown above, however, a more valid cost comparison, based on *average total cost of treatment*, will fix the ratio between 70 and 80%.

II. GENERAL INCIDENCE AND AVERAGE COST OF CHIROPRACTIC CARE AMONG OLDER PERSONS

One source of data which deals specifically with chiropractic care of older persons is some information contained in a research report prepared by Henry G. Higley, entitled "Chiropractic in Public Assistance Medical Care in the State of California.".[5]

This report shows the average cost of services per case under chiropractic care, under the California Old Age Security program, to be $33.11, compared to an average for all professions combined of $76.67. The period covered by the report was July, 1962 to June, 1964. The report also shows the percentage of those eligible who utilized chiropractic services, by six-month intervals within the 2 year period, as follows:

	Percent
July–December, 1962	3.66
January–June, 1963	3.88
July–December, 1963	3.71
January–June, 1964	3.72

These figures show a very stable rate of utilization of chiropractic services among persons eligible for Old Age Security Assistance. The total number of patients under chiropractic care during the 2 year period was 39,253.

In view of the deductible which applies to Part B of Medicare, it is of importance to have some knowledge of the distribution of chiropractic costs by size. To my knowledge, there is no data available on this matter which pertains specifically to persons above age 65. However, one study does exist[6] which presents statistics on distribution of costs under group and individual health insurance claims for spinal injuries generally, i.e., without regard to age. This study includes a continuance table showing the distribution by size of 982 such claims incurred in Oregon over a 9 month period ending in May, 1966. The average claim was $34.35:

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[4] "Chiropractic Survey and Statistical Study", Batten and Associates, Inc., 1963.

[5] "Chiropractic in Public Assistance Medical Care in the State of California", a Review and Data Analysis by Henry G. Higley, D.C. (published in March, 1968 issue of *The Chirogram*, Journal of the Los Angeles College of Chiropractic.

[6] "Summary of Cost of Chiropractic Care of Industrial, Auto, and Other Injuries Involving the Spine in the State of Oregon", a Review and Data Analysis by Henry G. Higley, D.C. (published in February, 1968 issue of *The Chirogram*).

Cost in dollars:	Number of claims
$1 to $10	209
$11 to $20	241
$21 to $30	174
$31 to $40	91
$41 to $50	66
$51 to $60	52
$61 to $70	42
$71 to $80	33
$81 to $90	18
$91 to $100	21
$101 to $110	12
$111 to $120	7
$121 to $150	11
$151 to $200	2
Over $200	3
Total	982

The same data, shown in more directly usable actuarial form, appears as follows, where Column 1, "Cumulative No. of Claims" means the number for which the cost equals or exceeds the dollar bracket, and is a reserve summation of the table above. Column 2 shows the corresponding amounts of dollars which fall in or above the bracket, and Column 3 shows the percentage of total charges which fell in or above the bracket:

Cost in dollars	Cumulative number of claims (1)	Cumulative dollars (2)	Cumulative percent (3)
$1 to $10	982	$33,740	100.0
$11 to $20	773	24,129	71.5
$21 to $30	532	16,881	50.0
$31 to $40	358	11,909	35.3
$41 to $50	267	8,622	25.6
$51 to $60	201	6,249	18.5
$61 to $70	149	4,453	13.2
$71 to $80	107	3,152	9.3
$81 to $90	74	2,231	6.6
$91 to $100	56	1,581	4.7
$101 to $110	35	1,126	3.3
$111 to $120	23	836	2.5
$121 to $150	16	641	1.9
$151 to $200	5	326	1.0
Over $200	3	135	.4

Since the average claim of $34.35 comes very close to the figure of $33.11 for California Old Age Security recipients, it appears reasonable to assume that the continuance patterns are fairly similar; in fact, the probability is that the Old Age Security pattern would be still more concentrated in the lower brackets. The cumulative percentage column above shows that only 18.5% of total charges would have exceeded a *per claim* deductible of $50. Part B of Medicare provides for a *calendar year*, not a per claim, deductible, but this data will nevertheless provide useful guidance in estimating what the costs would probably be if chiropractic services were included under Medicare.

As to the incidence of chiropractic care among older persons, the data cited above with respect to the California Old Age Security program is, of course, limited to California. Moreover, the number of licensed chiropractors in proportion to the population is very high in California. The publication *Health Manpower and Health Facilities, 1968*, of the United States Public Health Service, reports that while the number of licensed chiropractors per 100,000 population for the nation as a whole was 9.9 (as of December 31, 1965) the number per 100,000 in California was 22.2 more than twice the national average.

Accordingly, it is important to obtain some information as to the incidence of chiropractic care among the elderly in the national generally. Information on this score is available from U.S. Public Health Service publication No. 1000–

Series 10—No. 28.[7] For the period July 1963–June 1964, this source reported that, among persons age 65 and over, 2.9% made one or more visits to a chiropractor and the average number of visits per patient, during the survey year, was 5.0. As would be expected, this utilization rate is significantly lower than the average rate under the California Old Age Security program, for which the average, over a 6 month interval, was 3.74%. This national average of 2.9% may, however, be understated. The data was developed by sampling methods and there may be some further bias as a result of non-reporting, for the survey year, as to decedents. It would be most unlikely, however, that the true utilization rate, for the year, could have been any higher than about 3.5%, with an average number of visits per patient, for the year, of 6.0, at most.

III. ESTIMATION OF NET CHANGE IN COST RESULTING FROM INCLUSION OF CHIROPRACTIC SERVICES UNDER MEDICARE

At the very outset, it is essential to recognize that if the Medicare program were "expanded" to include chiropractic services, this would NOT represent an absolute addition to the program of an entirely new area of health care costs for which the program is presently paying nothing. Chiropractic care is in large measure an alternative to other types of professional care which are already included in Medicare, i.e., the services of medical and osteopathic doctors. This is obvious, since for certain types of ailments, any given individual may be just as inclined to seek care from a chiropractor as from, say, a medical doctor; provided only that his decision is not being influenced by such a factor as the absence of coverage under Medicare for chiropractic services. It does not *necessarily* follow, therefore, that net costs under Medicare would increase *at all* if chiropractic services were to be recognized. As already shown, the average total cost per case treated by chiropractic care is significantly lower than the average cost of medical or osteopathic care for similar conditions, ranging probably between 70 and 80% of the medical and osteopathic cost. Consequently, if, as a result of the extension of Medicare coverage to chiropractic services, some persons covered by Medicare who are now using the services of M.D.'s and D.O.'s were to obtain instead the services of D.C.'s for various conditions appropriate to chiropractic care, a net *decrease* in the cost of coverage for these persons would be the expected reslt.

Any valid and realistic estimate, therefore, of the net change in costs resulting from inclusion of chiropractic services must involve determination of a net balance resulting from offsetting changes. At this point it would be well to catalogue the several areas in which either increases or decreases are likely to occur.

A. AREAS LIKELY TO CONTRIBUTE TO *DECREASES* IN COST.

1. Alternative utilization of chiropractic services in lieu of medical or osteopathic services already being utilized under Medicare.

2. Elimination of hospital costs in those areas which currently involve hospitalization, but which, if treated chiropractically, would not result in hospitalization. An obvious example of this would be cases where hospitalization is utilized and the patient placed under traction by the medical doctor. The same ailment, treated chiropractically, would not involve hospitalization.

3. Elimination of the cost of drugs and biologicals currently administered by physicians as incidentals to professional services, in those cases where alternative chiropractic care of the same condition would involve drugless therapy.

In considering these areas of reduced utilization, however, it must be recognized that, since medical and osteopathic services, as well as hospital beds, are in short supply in many areas, some or all of the *reduction* in utilization resulting from alternative chiropractic care will be absorbed by *increased* utilization by other persons. Even if we assume, however, that released time and facilities will be absorbed 100% by other users, only about 25% of these other users will be Medicare eligibles, since this is roughly the percentage of total health care services being utilized by Medicare eligibles. Accordingly, in the estimates to be presented later in this study, I will assume that only 75% of any savings directly arising from alternative use of chiropractic services will actually count as *net* savings under the Medicare program.

It should be understood, however, that the remaining 25% of the savings regarded as "offset" by increases in utilization on the part of other users must not simply be ignored. For one thing, this means that more Total Care is being delivered under the Medicare program for the same dollars, which quite

[7] *Characteristics of Patients of Selected Types of Medical Specialists and Practitioners*, July 1963–June 1964: U.S. Public Health Service Publication No. 1000—Series 10—No. 28.

obviously represents a desirable improvement in efficiency. Secondly, this *offsetting* utilization is *not* chiropractic cost. It is *other* costs, which occur simply because *utilization* of chiropractic services releases facilities which are then available for other users. To evaluate this difference, I will also show what the estimated costs are when full account is taken of the direct reduction in utilization of other services made possible by the expansion of Medicare to include chiropractic services.

B. Areas Likely To Contribute to *Increases* in Cost.

1. Expansion of coverage to include chiropractic services currently being utilized by by persons eligible for Medicare.

Obviously, there are many persons who are currently using chiropractic services in spite of the fact that coverage of such services is excluded under Medicare. Expansion of the program to include chiropractic services would result in direct cost increases in these cases, to the extent charges exceed the $50 Medicare deductible.

2. Utilization of chiropractic services by persons who are now obtaining No Professional Care at all for certain ailments, but who would seek chiropractic care if it were covered.

In this particular area, it is rather difficult to find moral justification for the saving of costs by *excluding* chiropractic services, since such exclusion leads to the absence of any professional care at all. In fact, the eventual result of this situation, in many instances, may well be a net *increase* in cost, because neglect of the ailment may lead to its aggravation, with eventual expensive medical and hospital treatment. There are many rural and small town areas in the United States where the *only* local professional care available is from a chiropractor, so that the *exclusion* of chiropractic services under Medicare amounts to denial of local professional care of *any kind*, to a considerable number of people.

In this same area, it is pertinent to consider the question of the shortage of physicians. If there are persons who are not currently receiving needed care because of such shortage, and who would avail themselves of chiropractic care if this were covered, there would seem to be a strong moral consideration in support of the inclusion of chiropractic services under Medicare even if some net increase in cost *were* the result.

But let me now turn to the task of making some quantitative evaluation of the net probable effect of each of these areas on Medicare costs. For this purpose, I will draw on an assortment of statistics concerning the *first year* of operation of the medicare program, presented in a paper[8] by Dorothy P. Rice, of the Office of Research and Statistics of the Social Security Administration.

A. With Respect to Costs Under Part A of Medicare:

1. Benefits Paid in 1st Year: $2.5 billion.
2. Hospital admissions: 5,000,000=263 per each 1000 persons enrolled.
3. Persons hospitalized: 4,000,000 of the 19,000,000 enrolled, or 21%.
4. Average Medicare cost per admission: about $500.

B. With Respect to Costs under Part B of Medicare:

1. Benefits Paid in 1st Year: $700 million, although Mrs. Rice estimates that over $1 billion are potentially reimbursable, the difference being due to a "lag" in claim reporting and processing.

2. Persons utilizing services covered under Part B: About 12 million during each 6 month interval. [Probably during the entire 12 month period about 16,000,000 persons utilized such services.]

In the first 6 months, about 4 million persons, or 34% of those utilizing Part B services, exceeded the $50 deductible. In the second 6 months, over 5 million persons, or about 44% of those utilizing Part B services, exceeded the $50 deductible. [The second 6 months ended as of July 1, 1967, so for the full calendar year of 1967 the percentage would have continued to rise above 44%, since the $50 deductible applies to the calendar year.]

Now let us construct an estimated profile of chiropractic charges and utilization, if such services were included in Part B of Medicare.

Under the California Old Age Security program, it has been shown (page 5 of this report) that, on the average, about 3.74% of those eligible utilized chiropractic services in each 6 month period. A reasonable assumption would be that over a full calendar year about 5% would utilize such services.

[8] *Health Manpower and Health Facilities, 1968,* U.S. Public Health Service Publication No. 1509, 1968 Edition. (Table 23, page 50.)

For the nation as a whole, utilizing data developed by the U.S. Public Health Service, I have estimated (top of page 7 of this report) a *maximum* likely rate of utilization to be 3.5% with a ratio of licensed chiropractors per each 100,000 population less than half of that in California alone. The California utilization rate, however, is among persons covered for chiropractic services under a government program, whereas this would not be the case with this national utilization rate. If elderly persons nationally were covered under Medicare, one would, of course, expect some increase in the total utilization, even though Medicare coverage involves a $50 calendar year deductible and provides 80% coverage thereafter. Accordingly, it would seem unreasonable to assume a maximum utilization rate of any more than about 4% nationally, in relation to the 5% annual rate estimated for California where the number of chiropractors in proportion to the population is more than twice the national average, and where their services are covered without a $50 deductible.

This, then, would mean that out of the approximate number of 19,000,000 persons eligible for Medicare during its first year, 4% or about 760,000 would have utilized chiropractic services over a calendar year period.

This estimate also appears reasonable on other grounds. There are approximately 365,000 medical and osteopathic physicians in the United States. The U.S. Public Health Service estimates, that as of December 31, 1965, there were between 15,000 and 17,000 practicing chiropractic physicians.[9] If we take the upper bound of this estimate, that is, 17,000, the ratio of chiropractors to M.D.'s and D.O.'s is about 4.7%. If the services of chiropractors were used in the same proportion to their numbers as the services of M.D.'s and D.O.'s and an estimated 16,000,000 persons eligible under Medicare utilized the latter at least once during the course of a calendar year, then we obtain 750,000 as the estimated number utilizing chiropractic services, practically the same as the 760,000 estimate. By way of contrast, the data gathered in the Iowa Workmen's Compensation survey (page 2) showed the ratio of the number of back injury cases involving chiropractic treatment to the number involving M.D.'s and D.O.'s to be 18.3%. Here, the nature of the injuries involved is such that a far higher proportion of patients would be expected to obtain chiropractic treatment. Also, Iowa is another state, like California, with a high ratio of chiropractors to population: 21.3 per 100,000.[7]

To form an estimate of the expected profile of charges, I will utilize the Oregon continuance table profile (page 6), for which, as previously noted, the average cost of $34.35 is very close to the average of $33.11 for the California Old Age Security data.

Assuming a 3½% annual increase in costs, which should be reasonably accurate, an average cost of $34 in 1964 becomes $40 in 1969. Also, we need a calendar year figure, rather than per case, and a reasonable maximum adjustment is to increase the $40 by 50% to convert it to a calendar year figure, which thus becomes $60. Finally, the California program was subject to a Schedule of Maximum Allowances as to chiropractic services, and without this fixed schedule limitation on fees, the costs would have ranged about 20% higher. Thus our $60 becomes $72. This figure is 210% of the $34 average for the Oregon data, and if we assume a proportionate magnification of the continuance table, then about 45%, rather than 18.5% of the total charges will fall in excess of a $50 deductible on a calendar year basis. In other words, if *no other* Part B charges were incurred by a person eligible under Medicare in addition to chiropractic charges, then the average Medicare benefit payable over a calendar year woudl be 80%×45%×$72.00, or $27.70, assuming 100% of the charges to be deemed "reasonable," and thus eligible for payment as provided under the Medicare rules.

I have already shown that chiropractic services may be assumed to average between 70 and 80% of the average cost of the services of M.D.'s and D.O.'s for the same ailment, so, using a figure of 75%, the average M.D.–D.O. cost corresponding to the $72 D.C. average arrived at above is $96. Mrs. Rice's paper[10] shows the average recorded *bill* for physician's services to be $77, so on a calendar year basis my $96 estimate seems quite reasonable.

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[9] *Health Manpower and Health Facilities, 1968 (op. cit.)*, page 49.
[10] "Current Data from the Medicare Program" by Dorothy P. Rice, Office of Research and Statistics, Social Security Administration. Presented at the Statistics and Medical Care Section meeting of the American Public Health Association, Miami Beach, Florida, October 24, 1967.

For a $96 average for physician's services, approximately 60% of these total calendar year charges would fall in excess of a $50 calendar year deductible, so that, for a person incurring only *physician's* services over a calendar year, the average Medicare Part B benefit would be 80%×60%×$96.00, or $46 per person utilizing only physician's services (which would be about $740,000,000 per year, for the 16,000,000 persons I have estimated to utilize Part B of Medicare in its first year, not unreasonable in relation to Mrs. Rice's figures).

We are now ready to estimate the total *net change* in cost arising from expansion of Medicare coverage to include the chiropractic services utilized by the estimated 760,000 persons who would utilize such services (based, for the moment, on the number of persons eligible in the first year of Medicare).

Approximately 3,000,000 of the 19,000,000 persons enrolled in the first year of Medicare, or 16% of them, did not utilize any Part B services. Since about 18,000,000 actually enrolled for Part B, 1,000,000 of these were not covered under Part B in any case. Included in this 3,000,000 who did not utilize Part B would be that fraction of the 760,000 persons who were currently using chiropractic services, even through excluded from Medicare, and who were not utilizing any type of Part B service. It is reasonable to assume that this fraction is a higher percentage of the 760,000 than the 16% figure just mentioned, although it can hardly be drastically greater. A reasonable estimate would be that this fraction constitutes about 30% of the 760,000.

I estimated earlier that a national utilization rate among persons 65 and older for chiropractic services should not exceed 3.5%, and I estimated further that this could hardly be expected to rise any higher than about 4% if chiropractic services were included under Medicare. This represents a 15% increase, so we can reasonably expect that another 4.5% (15%×30%) of the 760,000 persons would use chiropractic services *if* they were covered, in lieu of other more expensive or less accessible professional care now covered by Part B of Medicare, and that this group, likewise, would in such event *not* also be utilizing *other* Part B services as well.

The remaining 65.5% of the 760,000 would then be utilizing *both* chiropractic and other Part B services, if the former were not excluded from Medicare, and a reasonable assumption is that this group would also divide in the ratio of 100 to 15 (that is, in the same ratio as I developed in the immediately preceding paragraph, in estimating the *increase* in chiropractic utilization if Medicare were to provide coverage) between those who are currently utilizing chiropractic services, in spite of their exclusion from Part B and, on the other hand, those who would avail themselves of chiropractic care as a *partial* alternative to other professional care, if only it were *not* excluded from Part B.

The 760,000 persons would then be distributed as follows:

(a) 30%, or 228,000, were those who were using chiropractic services currently. even though not included in Medicare, and, moreover, who were not utilizing any other type of Part B service. One-third of these, however, or 76,000, were not enrolled for Part B.

(b) 4.5%, or 34,000, were those who were using the services of M.D.'s or D.O.'s covered under Medicare, but who would utilize chiropractic services for the same ailments, if covered; and, moreover, were utilizing any other type of Part B service.

(c) 57%, or 433,000, were those corresponding to group (a), but who would *also* utilize other Part B services.

(d) 8.5%, or 65,000, were those corresponding to group (b), but who would *also* make partial utilization of other Part B services.

Thus far, we have taken into account 1969 *cost* levels, but not the 1969 enrolled population, since the 760,000 figure above is based on the 18,000,000 persons enrolled for Part B of Medicare in its *first year*. The number enrolled in 1969 is approximately 19,000,000, an increase of 5.5%, so the 760,000 must be increased by 5.5%, as well as each of the 4 population figures (a), (b), (c) and (d) above. These figures thus become:

(a) 241,000, of which 80,000 are not covered, leaving 161,000.

(b) 36,000.

(c) 457,000.

(d) 69,000; total 803,000.

For group (a), the Medicare benefit cost would be $27.70×161,000, or $4,450,000, and this would be 100% net increase in Medicare cost.

For group (b), the *present* cost of Medicare benefits, at an estimated $46 per person utilizing physicians' services, is $46×36,000, or $1,650,000, and we assume

that 75% of this, or $1,240,000 would actually be saved under Part B. If chiropractic care were covered under Medicare, the cost would be, instead, $27.70× 36,000, or $997,000. Thus group (b) would produce a net *decrease* in Medicare costs of the difference, or $243,000. If we count 100% of the savings, as discussed earlier, the net decrease for group (b) is $653,000.

For group (c), we must assume that a much higher percentage of cost falls in excess of the $50 deductible, since *other* Part B costs are *also* being incurred. The percentage will fall *between* 45% and 100%, since *some* of it will apply against the $50 deductible. An assumption of 80% is a reasonable estimate that should not *understate* this cost, so for this group the cost would be:

80%×80%×$72.00×457,000,, or $21,100,000, and all of this is net *increase.*

For group (d) the cost, if chiropractic services were covered, would be 80%× 80%×$72.00×69,000, or $3,180,000. However, under the existing program, let us assume that 85% of the substituted physicians' charges fall in excess of the $50 deductible, after counting the remaining Part B charges, in which case the present actual cost for alternate care of these same ailments comes to:

80%×85%×$96.00×69,000, or $4,447,000, and we assume that only 75% of this, or $3,340,000, will actually be saved under Part B.

Group (d), then, produces a net *decrease* of the difference between $3,340,000 and $3,,180,000, or $160,000. Again, if we count 100% of the savings, the net decrease is $1,267,000.

The net change for the 4 groups combined is:

	Counting 75 percent of savings	Counting 100 percent of savings
Group (a)	+4,450,000	+4,450,000
Group (b)	−243,000	−653,000
Group (c)	+21,100,000	+21,100,000
Group (d)	−160,000	−1,267,000
Net increase	$25,147,000	$23,630,000

For Part B alone, the "75% savings" figure is a net increase of just about 11 cents per month per enrollee, and under the Part B allocation formula, this cost is divided evenly between the Government and the participant, or 5.5 cents per month for each. If any margin exists at all in the monthly premium of $4.00 per enrollee (matched equally by the Government), this premium should be able easily to absorb such a minor increase, which is 1.38% of the $4.00 contribution rate. The "100% savings" figure equals 10.4 cents per month per enrollee, or 4.9 cents each for Government and participant.

We should not stop with this, because, as mentioned earlier, there are other areas of cost *decrease* to consider. A significant one is the matter of hospitalization costs that would be eliminated among those in Groups (b) and (d) who would use chiropractic care as an alternative.

Under the present program, I have cited Mrs. Rice's statistic that 4,000,000 covered persons were hospitalized during the first year of Medicare. Under my estimate of a total of 16,000,000 utilizing physicians' services during the first Medicare year, we have 1 out of every 4 persons using physicians' services becoming hospitalized. For the 105,000 persons in groups (b) and (d), a conservative assumption will be that a considerably *smaller* ratio of them would have become hospitalized under the present program but would *not* have been hospitalized under chiropractic care. The reason for this is that we are considering here people who, for the most part, would not be disabled by critically severe conditions necessitating major surgery and the like, so a smaller proportion of this group would become hospitalized under the *existing* program. Let us assume only a quarter of the ratio: 1 out of 16. Let us, moreover, assume that among these the average Medicare cost per admission is only ½ the overall average reported by Mrs. Rice, or $250 instead of $500, again due to the milder nature of their conditions. Then the *eliminated* Medicare hospital cost, among these 105,000 persons, is:

1/16 × 105,000 × $250.00, or $1,640,000. Again, we count only 75% of this as actual net savings, or $1,220,000.

This projected savings of $1,220,000, which would develop under Part A of Medicare, would therefore be a 100% offset against the Government's Part A disbursements from the Hospital Insurance Trust Fund, and the net increase

in cost, to the Federal Government, would thus be $12,573,000 (its share of the net increase under Part B) less this $1,220,000, or $11,353,000, which comes to about 4.98 cents per month per Part B enrollee. Counting the savings on a 100% basis, the net increase to the Government is $11,815,000 less $1,640,000, or $10,-175,000, which is 4.46 cents per month per enrollee.

There are, furthermore, still other areas of decrease; most obviously, out-patient diagnostic charges. We have considered enough, however, to clearly establish the conclusion that even under reasonably conservative actuarial assumptions, expansion of Medicare to include chiropractic services can hardly result in a net increase in costs to the Government of any more than about 5 cents per month per enrollee.

It is my understanding that some estimates of the increased cost of including chiropractic services in Medicare have ranged as high as $60 million annually. The foregoing considerations at least should clearly demonstrate that this is greatly exaggerated. Even if we were to assume *no savings at all* in costs under Part A, and even if we were to assume that every penny of chiropractic charges for the 723,000 estimated enrolled persons fell *in excess* of the $50 deductible, and, further, if we were to assume that not one penny of this cost would offset *any* other costs being incurred by the program, the resulting estimated cost would still not exceed:

80% × $72.00 × 723,000, or $41,700,000 annually:

The $50 Part B deductible, however, is simply too great a factor to be disregarded, even in projecting a so-called "high cost" estimate. Sufficient conservation exists in the various assumptions I have made so that a reasonable "high cost" estimate can be obtained simply by ignoring the net "offsetting" items of savings I have taken into account. Thus, considering each of the 4 groups analyzed previously, we would have:

	Number	Cost
Group (a)	161,000	$4,450,000
Group (b)	36,000	997,000
Group (c)	457,000	21,100,000
Group (d)	69,000	3,180,000
Total	723,000	29,727,000

Note.—This amounts to 13 cents per month per part B enrollee.

IV. CONFIRMATION FROM EXPERIENCE OF COMMERCIAL INSURANCE COMPANIES

It must be recognized that a number of the assumptions I have used in the preceding analysis are partly conjectural and therefore subject to differences of opinion and to some measures of potential error. Accordingly, it is highly desirable to find some independent source of confirmation of the reasonableness of the overall conclusions reached in Section III of the study. Such an independent source does exist and it may be found in the experience of commercial insurance carriers. In behalf of one of my commercial company clients, I recently had occasion to study this same question, i.e., the cost of extending coverage to chiropractic services, and in connection with this study I interrogated 19 major health insurance writers as to their experience resulting from such extension of coverage. All of these are large carriers, operating in most states, and all have at least some experience in relation to recognition of chiropractic services, since in several states insurance laws enacted in the last few years have required that carriers recognize chiropractors for any covered services they are legally qualified to perform. The 19 carriers combined, in 1967, wrote health insurance premiums totaling $3,879,000,000, or 44% of all the commercial health insurance in the United States; so their combined experience represents a large fraction of the total health insurance experience of the country. Several of them are also participants in the administration of the Medicare program.

Here is a summary of the responses of the 19 companies to my inquiry:

(1) 15 out of the 19 companies are now voluntarily recognizing chiropractic services in all states, not only those where they are legally obliged to do so. The majority of these 15 have been following this practice for many years. The remaining 4 are recognizing chiropractors only in the several states where they are legally required to do so.

(2) 9 of the 19 companies reported that they have detected no apparent change in total claim payout which they could attribute to the inclusion of chiropractic services. 2 of the 19 were of the opinion that a slight increase in costs had resulted, although in neither case was this opinion a clearly established statistical fact: it was, rather, an impression based only on general observations. The remaining 8 did not have an answer to the question of *change* in cost, for the most part because their practice of recognizing chiropractors dated back so far that no basis of comparison existed. All of the statistical data of these 8 included coverage of chiropractors for those covered services they are legally qualified to perform.

(3) Of the 4 carriers recognizing chiropractors only in those states where legally required, which requirement has in most such states been of recent enactment, 3 reported *no apparent change in costs* in those states. The 4th did not have an opinion, having not yet analyzed their experience to draw any conclusion on this score.

The general conclusion to be reached from this survey of commercial carriers is that *no significant net change* in costs resulted from their expansion of coverage to chiropractic services. Several of these carriers have large volumes of group hospital and medical insurance in force, and a change of as much as 2% in costs under such programs, resulting from expansion of coverage to a new area of professional services, such as chiropractic, would be "significant". *None* of them were of the opinion that any increase of even these modest proportions had occurred. My "probable maximum" estimate of the net increase in costs under Part B alone, for 1969, is 11 cents per month per enrollee (page 14 of this report). This represents approximately 1.4% of the $8.00 per month contributed by the Government and each enrollee, combined, and is of about the size, percentage-wise, where a large commercial group writer would begin to take definite note of its presence in total cost allocations. In short, the experience of commercial carriers would support the conclusion that my estimate is *conservative*, and that the probability is that the actual costs of chiropractic care under a program such as Part B of Medicare will be *less* than what I have projected.

It must be recognized that some of the *coverage* which the 19 large carriers have in force would provide only *limited* coverage of chiropractic services. For example, hospital-surgical policies covering only "in-hospital" physicians' visits would provide essentially no chiropractic coverage at all. On the other hand, however, comprehensive medical policies with low deductibles would provide broad coverage of chiropractic charges, and on a basis quite similar to Medicare, with deductibles such as $50 per calendar year, etc. Some of these carriers have very substantial volumes of this type of coverage in force. If these carriers have detected *no* apparent increase in claim costs resulting from recognition of chiropractors, it seems most likely that *little* increase will result under Medicare either, a result consistent with what I have projected in the calculations summarized in Section III of this study.

V. SUMMARY OF CONCLUSIONS

By way of summarizing the various considerations I have attempted to evaluate, I obtain the following as estimates of what the cost would have been, during the year 1969, if chiropractic services were covered under Medicare:

PROJECTED MONTHLY COST, PER PART B ENROLLEE, OF CHIROPRACTIC SERVICES INCLUDED IN MEDICARE DURING 1969

1. "High cost" estimate, taking no account whatever of any offsetting savings in existing Medicare payments: 13 cents. [Page 15 of this study]

Since the cost of Part B is divided equally between the Federal Government and the individual participants, the Government's share of this high cost estimate is 6.5 cents.

2. "Probable maximum" estimate for Part B alone, taking account only of the likely actual net savings in other Part B payments: 11 cents. [Page 14 of this study]

The Federal Government's share would be 5.5 cents.

3. "Probable maximum" estimate of the net increase in costs under Parts A and B combined, taking account of likely actual net savings under *both*: 10.5 cents.

The Federal Government's share, as the net difference between its Part B cost and the savings to the Part A Trust Fund, is 4.98 cents. [Page 15 of this study]

4. "Low cost" estimate, taking full account of the offsetting savings arising *directly* from the shift to alternate chiropractic care: 9.6 cents.

The Federal Government's share, as the net different between its Part B cost and the savings to the Part A Trust Fund, is 4.46 cents. [Page 15 of this study]

Respectfully submitted,

E. PAUL BARNHART, F.S.A.,
Consulting Actuary.

APPENDIX A

CRITIQUE OF ACTUARIAL COST ESTIMATE ON CHIROPRACTIC SERVICES UNDER MEDICARE PREPARED BY ACTUARIAL DIVISION OF SOCIAL SECURITY ADMINISTRATION

The cost estimates which I have developed in the preceding study are much lower than estimates developed by the Actuarial Division of the Social Security Administration. The latter are presented in a memorandum from Mr. William Hsiao, F.S.A. to Mr. Robert J. Myers, Chief Actuary of the Actuarial Division of S.S.A., dated February 13, 1969.

By way of presenting a concise comparison between the two studies, here is a summary of the conclusions.

Mr. Hsiao made two determinations of the estimated cost, using two separate approaches, as follows:

1. An estimate based on gross annual income of chiropractors, together with the percentage of this income assumed to be derived from persons over 65. The assumptions are:

(*a*) Number of chiropractors in private practice: 23,000.

(*b*) Average gross income in 1969: $19,000.

(*c*) Percentage of this income assumed to derive from patients 65 and older: 23.1%.

(*d*) Percentage of (*c*) remaining after deducting the $50 Part B deductible and the 20% "coinsurance" under Part B: 63%.

These 4 assumptions lead to the calculation 23,000 × $19,000 × 23.1% × 63%=$63,600,000 as the estimated *benefit cost.*

Administrative expenses are assumed to be 11.5%, so total cost is projected as $63,600,000 × 111.5%, or $70,900,000 which is 31 cents per month per enrollee.

2. An estimate based on utilization rates and cost per visit. The assumptions are:

(*a*) Percentage of aged population utilizing chiropractic services when *not* reimbursable under SMI 4½%.

(*b*) Additional 1 to 1½% assumed to utilize when covered by SMI, but cost offset by corresponding decrease in utilization of "physicians". (i.e., no change on this account.)

(*c*) Utilization rate: 12 visits per year per patient.

(*d*) Average cost per visit: $7.

(*e*) Percentage remaining after deducting deductible and coinsurance: 63%.

These assumptions lead to the calculation 19,000,000 (population enrolled) × 4½% × 12 × $7 × 63% = $45,200,000 as the estimated *benefit cost.*

Again, adding administrative expense of 11.5%, the total cost is projected as $45,200,000 × 111.5%, or $50,400,000 which is 22 cents per month per enrollee.

My study does *not* attempt to measure administrative cost, since I have no information on this score (other than Mr. Hsiao's 11.5%). My only comment is that 11.5% seems excessively high, since large commercial insurance carriers are known to be able to administer large group medical benefit plans for as little as 4 or 5%, and I find it remarkable that the administrative costs under Part B of Medicare should prove to be as high as 11.5%. Nevertheless, I will not attempt to delve further into the question of costs of Federal administration. To make the estimates of the two studies fully comparable, we should therefore consider *benefit costs* only, which are what my study undertakes to evaluate, and these, to recapitulate, are as follows:

SSA estimate:

Method 1: $63,600.000, or 28 cents/mo./enrollee.

Method 2: $45,200,000, or 19.8 cents/mo./enrollee.

From these two estimates, Mr. Hsiao concludes that a figure half-way in between, or about 24 cents/mo./enrolle (26 cents including administrative cost) is the "most probable"additional cost to include chiropractic services.

My estimates were as follows:

1. "High cost": $29,727,000, or 13 cents/mo./enrollee.
2. "Probable Maximum", Part B alone: $25,147,000, or 11 cents/mo./enrollee.
3. "Probable Maximum". A and B combined: $23,927,000, or 10.5 cents/mo./enrollee.
4. "Lost cost": $21,990,000, or 9.6 cents/mo./enrollee.

My basic estimate is No. 2, 11 cents per month, *less than half* Mr. Hsiao's concluding 24 cent estimate. In view of this very drastic difference in estimates, some comment is in order as to what factors may account for this large difference.

The significant factors are as follows:

1. Mr. Hsiao uses 23,000 as his estimate of the "number of chiropractors in private practice." His source for this figure is "Health Resources Statistics, 1965," *Public Health Service Publication No. 1509.*

A later edition of this same publication, however, "Health Resources Statistics, 1968", *Public Health Service Publication No. 1509* (1968 Edition) states, on page 49:

> About 19,100 chiropractors were licensed at the end of 1965 in the United States, according to estimates based on a survey published in the American Chiropractic Association's Journal of Chiropractic (table 23). Of the 19,100 chiropractors, licensed in 1965 in the United States, perhaps 15,000 to 17,000 were actively engaged in practice at that time. This is substantially less than had been estimated in the earlier edition of this publication.

Thus, at the very outset, using Mr. Hsiao's own source of information, we must conclude that a figure of 17,000, at most, rather than 23,000, is appropriate. This *alone* will reduce Mr. Hsiao's method 1 result by 26%.

2. Under both methods 1 and 2, Mr. Hsiao assumes that 63% of chiropractic charges will remain as reimbursable after subtracting the $50 Deductible and the 20% coinsurance. He gives no *direct* justification for this assumption at all, stating merely that "A reasonable assumption is that 63% of the chiropractor's charges to SMI enrollees will be reimbursed by the Medicare program".

The indirect justification offered for this very broad assumption is as follows: He states that "the Current Medicare Survey shows that among the SMI enrollees who utilized covered services in 1967, 63% of the incurred costs are potentially reimbursable after taken into account of [sic] deductible and coinsurance", and adds, "Because of the increase in physicians' fees and utilization, we would expect a larger percentage of the incurred costs to be potentially reimbursable in 1969. On the other hand, we know from actual experience that many enrollees do not file claims for one reason or another". Elsewhere, he states that "the fees charged by the chiropractors as compared with physician's fees in performing similar services might be approximately 10% less".

Now, even using this "10% less", Mr. Hsiao should logically come to the conclusion that, if 63% of *M.D.* and *D.O.* incurred costs were "potentially reimbursable" [note that he does NOT say "actually reimbursed"] in 1967, *then something less than 63%* of chiropractic charges would have been "potentially reimbursable". This is the conclusion one *has* to reach, if chiropractic charges "might be approximately 10% less". If they are 10% less, then a *lesser* fraction than 63% will *necessarily* remain after subtracting the $50 Deductible and 20% of what exceeds this Deductible. But this "10% less" is not the whole story by any means. As pointed out in my own study (page 4), comparative costs must be determined in relation to *average total cost of treatment*, NOT on the basis simply of average charge per office visit, as used by Mr. Hsiao in arriving at his "10% less". My own study develops, at considerable length, justification for the conclusion that the ratio of chiropractic total costs to M.D. and D.O. total costs falls between 70 and 80%. I further develop, in considerable detail, a basis for estimating what fraction of chiropractic costs may be expected to exceed the $50 Medicare Part B deductible (see pages 6 and 7, and subsequently pages 11 and 13). I was led to the conclusion that, in the absence of *other* Part B services, 45% of chiropractic costs would exceed the $50 deductible and 80% *of this* would be reimbursable, or *36%*, compared to Mr. Hsiao's 63%.

Among persons incurring *other* Part B expenses, I concluded that *80%* of chiropractic costs would exceed the $50 deductible, so with 80% of this reimbursable we have 64%, close to Mr. Hsiao's 63% for this *portion* of the utilizing population, but only by coincidence.

I provide extensive analysis and support for my percentages, whereas Mr. Hsiao's supporting discussion actually *contradicts* his conclusion, since the same

63% can hardly be valid for *both* chiropractic charges and also presently reimbursable charges if the former average "10% less". *Charges* which are 10% less would *necessarily* result in a lesser fraction than 63% remaining reimbursable above the $50 Deductible.

Based on my own analysis, and the relative numbers involved in each of my population categories (page 12), one can reasonably conclude that a *composite* percentage for all enrollees utilizing chiropractic services would be close to:

(34.5%×36%)+(65.5%×64%), or 54%, as a conservative estimate

Adjustment of Mr. Hsiao's 63% to this rather more supportable figure of 54% would reduce *both* his method 1 and method 2 estimates by 14.3%, without considering *any* of the other adjustments needed. Finally, this 54% remains as a "potentially reimbursable" estimate, rather than an estimate of what would be "actually reimbursable".

3. In his method 2, Mr. Hsiao adopts, as his estimate of the number of visits per year per patient, 12. For his derivation of this, he refers us to page 4 of his memorandum, where he begins, "In this area, there is very little data", and cites 3 sources:

(*a*) The Batten and Associates' study (my footnote 4), which showed an "average number of treatments per patient in 1962 as 10". Mr. Hsiao continues "it is unclear in that report whether this average is on a calendar year basis or is per illness". As a matter of fact, it is not clear that *either* is meant by the Batten report. All it says is "average number of treatments per patient". Over 30% of the respondents (chiropractors surveyed by mail) reported 6 or fewer visits per patient. More than 17%, on the other hand, reported over 20 visits per patient. This suggests that the respondents themselves did not all have the same parameter in mind in their answers (some may well have meant "total treatment *history* per average patient"), which leaves this whole source highly suspect.

Mr. Hsiao finally adds the comment, "from public health data, we know the aged population make ⅓ more visits to physicians than people under age 65". (Source: "Volume of Physician Visits, United States—July 1966–June 1967": National Center for Health Statistics, Series 10, No. 49.) This data pertains to physicians' visits in general, not to *chiropractic* visits as such.

As to his sources, Mr. Hsiao completely neglects another pertinent U.S. Public Health Service publication to which he does, however, refer elsewhere in his memorandum. This is Public Health Service Publication No. 1000, Series 10, No. 28, to which he refers on page 3 of his memo, where he comments that it "showed approximately 2.9% of the aged population had utilized some chiropractic services during the period July 1963 through June 1964". The 2.9% figure appears on page 38 of the report. On the opposite page (page 39), the report *also* shows that among persons 65 and older the "number of visits per patient per year" was 5.0 (less than *half* of the average number, 12, eventually assumed by Mr. Hsiao).

(*b*) California Old-Age Security data, wherein the average number of visits to a chiropractor in a 6-month period was 7.

As pointed out in my study (page 6), the ratio of chiropractors to population in California is more than twice the national average. Further, the data cited are developed under a public aid program that involves *no deductible at all*. Consequently, I cannot accept this "7 per 6 months" statistics as very indicative of the expected number per year under Part B Medicare enrollees if chiropractic services were covered.

(*c*) My own earlier study of June 1968, citing data published by the Florida Chiropractic Association in 1960, which showed the "average number of treatments per case" with respect to sprains and strains of the neck, spinal vertebrae and external back, to be 9. This data, dealing as it does with a very narrowly circumscribed category of ailments, can hardly be taken as indicative of the average number of visits, *for all causes*, to chiropractors on the part of persons over 65 in general.

Elsewhere in his own memorandum, Mr. Hsiao himself quotes another pertinent statistic, which he does not appear to have considered in deriving his estimate of 12 visits. On page 5, under "Aggregate Cost" he refers to a "Current Medicare Survey" which showed that enrollees under SMI had utilized chiropractic services amounting to $10,978,000 during a 9-month period in 1967 and 1968. He adds "Interestingly enough, the average number of visits per patient for this 9-month period was only 3.9." If expanded, proportionately, to 12 months, the 3.9 becomes 5.2, highly consistent with the 5.0 cited by Public Health Service Publication No. 1000, Series 10, No. 28. Thus what would appear to me to have been the two most

pertinent and reliable sources of data available to Mr. Hsiao on this specific point are *both ignored* and also *both closely consistent:* 5.0 visits and 5.2 visits, respectively. It seems extremely unlikely that, as a result of the extension of $50 Deductible Part B Medicare coverage to chiropractic services, this rate of 5 visits per year could possibly rise to any more than about 7.

My own conclusion from all this, then, is that a more realistic upper estimate of the number of visits per year to be anticipated under Medicare would be about 7, rather than 12. Adjustment of this figure *alone*, disregarding all the other adjustments I suggest should be made, would reduce Mr. Hsiao's method 2 cost estimate by a whopping 42%.

4. Under method 1, Mr. Hsiao assumes that 23.1% of the gross income of chiropractors will derive from patients age 65 and over. His source for this is data limited to California (page 4 of his memorandum). This was data compiled by the Stanford Research Institute which Mr. Hsiao states "concluded that almost 33% of the chiropractic patients were people 60 years of age and older". He then adjusts the 33% to 23.1% (page 12 of his memo) by using general population ratios to screen out the 60–64 age group.

As an independent test of the validity of this procedure (which again involves the questionable process of applying *California* percentages to the nation as a whole) let me once again refer to Public Health Service Publication No. 1000–Series 10, No. 28. If we consider *number of patients* (Table 21) we find from this particular source that approximately 11.7% of all chiropractic *patients* were persons age 65 or over (for the year July 1963–July 1964).

If we consider *number of visits* (obviously a better index of the proportion of *total care* and hence *total income* deriving from persons age 65 and over than number of *patients* only) we find from this source (Table 22) that approximately 12.6% of all visits to chiropractors were made by persons age 65 or older. This is a long way from Mr. Hsiao's 23.1%. The 12.6% however, should be adjusted for the expected increase in Medicare covered utilization of chiropractic services. Making this adjustment consistently with equivalent adjustments made in my study to account for this we increase the number of patients by 15% and the number of visits per patient by about one-third obtaining:

$$12.6\% \times 1.15 \times 1.33 = 19.2\%$$

If Mr. Hsiao's 23.1% is modified to this 19.2% which is actually *based* on national data from the Public Health Service figures his method 1 result disregarding *all other* adjustments, would reduce by 17%.

5. In method 2, Mr. Hsiao adopts, as his estimate of the fraction of persons age 65 or over who utilize chiropractic services, *without* Medicare coverage 4½%. My own study arrives at 3½% (page 6) increasing this to 4% (page 9) as a *result* of extension of Part B coverage to chiropractic services.

As support for his 4½% assumption Mr. Hsiao cites the following (page 3 of his memo):

(*a*) Again PHS Publication No. 1000 Series 10 No. 28 to which reference has been made several times. As previously mentioned this showed 2.9% of the aged population utilizing some chiropractic services over a 1 year period. Mr. Hsiao adds, "However, this survey omitted one important group, decedents. From prior experience the adjustment for decedents can be as high as 40%–50%". A full 50% adjustment would blow the 2.9% up to 4.35%. However while such a pronounced adjustment could well be called for as to M.D. attendance upon aged individuals I find it inconceivable that any comparable adjustment would be appropriate for chiropractic care assuming as it does a heavy attendance by chiropractors upon terminal illnesses among the aged. My own adjustment of this figure to 3.5% seems much more within realistic bounds.

(*b*) The California Old-Age Security data showing an average 3.74% utilization each 6 months. I have estimated that adjustment of this rate to a 12 month basis would raise it to 5%. However as I have pointed out previously, this data relates (1) to a state where the ratio of chiropractors to population is more than twice the national average, and (2) to utilization under a government program with *no deductible at all*. If the existence of Medicare coverage, with a $50 calendar year deductible can be expected to increase utilization of chiropractic services, then coverage under a no deductible program would surely increase it even more. I therefore find it unreasonable to assume on the support of this California data, that the national utilization rate, *without* governmental coverage, should be as high as 4½%.

(*c*) A "Current Medicare Survey" which Mr. Hsiao states was conducted by the Bureau of the Census for the Social Security Administration in February

1969. Mr. Hsiao tells us that this source showed that in the 9 month period October 1967 through June 1968 5.4% of SMI enrollees utilized chiropractic services even though excluded from Medicare. If so this would indeed suggest that 4½% is not an excessive estimate. However, this 5.4% figure (over 9 months) is highly inconsistent with the PHS Publication 1000 figure of 2.9% over 12 months, and, in my opinion, also seems most unlikely in relation to the California Old Age Security data. It would be of interest to know more about this "Current Medicare Survey" and its methodology; however upon inquiry I learn that this Survey was never published. Apparently it was a special tabulation made for SSA use and is unavailable.

In the absence of more convincing supporting data to the contrary, I find my 3½% estimate, going to 4% in the presence of Medicare coverage assumed to include chiropractic services, to be considerably more realistic and supportable. However, as I will show shortly, even if we *accept* Mr. Hsiao's 4½%, adjustment of his calculations in relation to the first 4 factors discussed above will bring his figures well down into the range of my own benefit cost estimates.

6. In method 1, Mr. Hsiao assumes that the average gross income of chiropractors in 1969 is $19,000. His support for this assumption goes back to the Batten and Associates' study of 1962, which reported average gross income of $14,000. To arrive at $19,000 in 1969, Mr. Hsiao applies a 36% increase, "according to the physician's fee component of Consumer Price Index." I regard this 36% factor as rather questionable on the basis of Mr. Hsiao's own findings (pages 9 and 10 of his memo) that there is "unused capacity" among the chiropractors. He also comments (page 9) that "today, the utilization of physicians' services has largely been held down by the scarcity of medical doctors." Simple operation of the economic law of supply and demand would suggest that the fees and incomes of medical doctors would have increased, over the 7 years, by a larger percentage than those of chiropractors. Other than regarding it as a dubious figure, however, let us accept the $19,000 gross income figure. As I've mentioned, adjustment on account of the first 4 factors alone, discussed above, will bring Mr. Hsiao's estimates into reasonable consistency with the cost estimates of my own study.

7. Mr. Hsiao devotes a considerable portion of his memorandum to the subject of the training and qualifications of chiropractors and the scope of illnesses treated by them, and concludes from his discussion (page 9) "that the fair and reasonable approach is to assume that any factors which tend to increase the cost will be offset by the factors which tend to reduce the cost." He cites, as considerations tending to *increase* the ultimate costs resulting from chiropractic care, the following:

> (*a*) Page 7: "Questions have been frequently raised as to whether chiropractors have the training and qualifications to be a substitutive form *for all types* of physicians' services." [italics mine] To begin with, I am not aware that anyone is *suggesting* substitution "for all types" of physicians services. In my study, I have merely taken it for granted that chiropractors, under Medicare, would perform services within the customary range of their practice and which they are *legally licensed to perform.* I make no pretense of evaluating any further the relative *efficacy* of chiropractic care as compared to care by medical or osteopathic doctors—one way or the other. I know of no statistics available by which one may make any such evaluation, and, since Mr. Hsiao cites no such statistics, I presume he knows of none either.

Apparently Mr. Hsiao assumes that chiropractors generally undertake to treat every form of illness, on the basis of information in the Batten and Associates study (page 2 of his memorandum) which indicated that chiropractors reported having treated a very wide range of conditions. I note, for example, that 9% reported "having treated" fractures; 7% reported "having treated" cancer I find it extremely difficult to determine what meaning, if any, to ascribe to such information. I derive somewhat more significance from another chart in the Batten Study entitled "Illnesses Most Frequently Treated." The six "most frequent," together with the frequency index used in the Batten Study, are:

Headache	2009
Lumbo-sacral strain or sprain	1645
Low back disorders	1629
Cervical subluxations (neck, head)	1558
Spinal subluxations	957
Sacro-iliac strains	868

Among the conditions cited by Mr. Hsiao as having been treated by a very large percentage of chiropractors are the following:

	Percent
Sinusitis	94
Constipation	94
High blood pressure	93
Asthma	89
Bronchitis	86
Gall bladder	82
Ulcers	76

These same 7 conditions, in the scale of "Most Frequently Treated" illnesses, show the following frequency indexes:

Sinusitis	284
Constipation	87
High blood pressure	167
Asthma	140
Bronchitis	17
Gall bladder	61
Ulcers	26

Thus, as to *frequency* of treatment, these 7 conditions each tend to develop, as a rough average, about 6 or 7% of the average frequency of each of the top six, even though 76 to 94% of chiropractors reported "having treated" them.

Also of interest are the following observations:

(1) Mr. Hsiao states "the method of obtaining these diagnoses is unknown", and elsewhere says "the results from possible incorrect diagnosis and treatment might require some patients to be hospitalized, whereas the need might not arise if they were under the care of physicians". Since, in Mr. Hsiao's opinion, chiropractors have dubious qualifications even to diagnose correctly many of his listed conditions, one wonders why he implies that the *list* of conditions treated holds any real significance in the first place.

(2) As mentioned in my study (page 8), there are a good many rural and small town localities where the only local practitioner *available* is a chiropractor. In view of this fact, it is hardly surprising that we find chiropractors reporting "treatment" of a pretty wide range of conditions, including an interesting one not mentioned by Mr. Hsiao: obstetric service, for which 7% of chiropractors report having given "treatment".

> (b) Page 8: "In many cases, the wrong diagnosis might be made or incorrect treatments given. The patients' conditions will be aggravated and might require more expensive treatments or hospitalization. This will increase the cost of the Medicare program." Again, on page 9: "the results from possible incorrect diagnosis and treatment might require some patients to be hospitalized, whereas the need might not arise if they were under the care of physicians."
>
> Mr. Hsiao goes on to concede (page 9): "there is no "direct" [quotes mine] statistical information *whatsoever* [italics mine] to shed any light on this question."

Which is precisely the point. Mr. Hsiao admits he has no statistical evidence "whatsoever." Nor does he suggest what "indirect" evidence throws any real light on the matter, either. He is merely theorizing. Accordingly, I question that he really has any justification at all for concluding that these influences *will*, in fact, *offset* other influences for which we *do* have statistical evidence indicating they *do* produce cost savings. He does, specifically, assume that such an offset *will* occur, as a "fair and reasonable" approach. My study, for example (pages 1–4) presents considerable *statistical evidence* that in the specific area of sprains and strains of the back, chiropractic total treatment costs are *less* than treatment by M.D.'s and D.O.'s. Accordingly, in the light of known statistical evidence on this score, and the total absence of statistical evidence *of any kind* supporting Mr. Hsiao's *theories* about the relative efficacy of chiropractic care, I feel justified in assuming certain offsetting *savings*, as described in my study.

Our task in these studies, after all, is a *statistical* and *quantitative* one. I do not regard our task as one that extends to that of making evaluations as to the relative adequacy or efficacy of chiropractic care as compared to medical or osteopathic care. My professional competence lies in dealing with statistical data and actuarial probabilities—*not* in evaluating the relative potency of different forms of legally licensed health care services.

Let me now adjust Mr. Hsiao's calculations in relation to the first four only, of the seven factors I have discussed. These were:

(1) 17,000 is a supportable estimate of the number of practicing chiropractors, rather than 23,000.

(2) 54% is a more supportable estimate of the fraction of chiropractic charges "potentially reimbursable" under Medicare than 63%.

(3) 7 is a more supportable estimate of the number of visits per year (under Medicare coverage) than 12.

(4) 19.2% is a more supportable estimate of the percentage of chiropractors' gross income derived from patients 65 and over (in the presence of Medicare coverage) than 23.1%.

If recalculations are made, using these 4 adjustments we obtain:

For Mr. Hsiao's method 1:

Benefit cost=17,000×$19,000×19.2%×54%=$33,489,000 (vs. his $63,600,000).

For method 2:

Benefit cost=19,000,000×4½%×7 visits×$7/visit×54%=$22,623,000 (vs. his $45,200,000).

Using his same concluding assumption, namely that the "most probable additional cost to cover chiropractic services" is simply the arithmetic mean of these two estimates, we conclude with a figure of $28,055,000.

This figure is an estimate that *ignores* any "offsetting savings." My comparable estimate is my "High Cost" estimate, No. 1, which is $29,727,000.

The two are pretty close.

In conclusion, I feel obliged to refer to these comments made in Mr. Hsiao's conclusion:

> The most probable additional cost to cover chiropractic services is estimated to be $60 million in 1969. . . . This estimate is reasonable in light of the information that the people enrolled under SMI had spent approximately $27 million for chiropractic services in a recent 12 month period, even though these charges are not reimbursable by the program.

I propose that, in relation to the $27,000,000 statistic, an estimate of $60,000,000 is very, very *unreasonable.*

The *benefit cost*, relating to the $60,000,000, would be net of 11.5% administrative cost and equal to $54,000,000.

Since Mr. Hsiao has assumed that 63% of the chiropractic charges incurred are "potentially reimbursable", this $54,000,000 is only 63% of the assumed *charges*, which in turn means that he has assumed that the SMI enrollees would have *incurred charges* totalling $86,000,000 for chiropractic services if only these had been covered by Medicare.

However, in the *absence* of Medicare coverage, they incurred only $27,000,000 (this figure being expanded to 12 months from the $19,978,000 over 9 months, reported by Mr. Hsiao as the finding of the "Current Medicare Survey") of chiropractic charges.

In other words, Mr. Hsiao finds it "reasonable" to conclude that, purely and directly as a result of extending $50 deductible, 80% coverage Part B of Medicare to include chiropractic services, the SMI enrollees would *increase* their expenditures for chiropractic care by $59,000,000, or 218%!! In other words, their expenditures for chiropractic care would more than triple, from $27,000,000 to $86,000,000!! If such an amazing conclusion is indeed to be deemed "reasonable", then this is a most crucial matter of public policy indeed for Congress to consider, since it would indicate that a substantial portion of the public are being denied health services which they *want* and would *use* to a greatly increased degree if only Congress would recognize these desired services under the Medicare program.

Respectfully submitted.

E. PAUL BARNHART, F.S.A.,
Consulting Actuary.

COLONIAL PENN LIFE INSURANCE CO.,
Philadelphia, Pa., November 20, 1969.

Dr. GERALD M. BRASSARD,
Beaumont, Tex.

DEAR DR. BRASSARD: At the request of Mr. Jul Baumann, we are pleased to furnish you with the following information:

1. Our company offers to members of AARP and NRTA Accident and Health individual contracts.
2. By virtue of being members of AARP and NRTA, they become eligible to apply for this coverage.
3. The policyholder htas freedom of choice in the selection of his doctor, whether he be in Maryland or D.C.
4. We have no extra charges attached to our contracts for the inclusion of chiropractors, if they are chosen by the patient.

Please feel free to let us know if there is any further information with which we can furnish you.

Very truly yours,

JAY J. ERDE,
Secretary and Counsel.

The CHAIRMAN. That will conclude the presentation for the chiropractors.

Next we will have Mr. C. Ross Cunningham, manager of the Washington office of the Christian Science Committee on Publication.

Senator TALMADGE. Mr. Chairman, it is going to be necessary for me to leave the committee and go to the floor of the Senate. We have a later witness, also one of my friends and constituents, Dr. E. Dalton McGlamry who is first vice president of the American Podiatry Association, of Atlanta, Ga., and it is a pleasure for me to welcome him to the committee.

The CHAIRMAN. We will take note of that, Senator. I am sorry you can't be here all the time.

STATEMENT OF C. ROSS CUNNINGHAM, MANAGER OF THE WASHINGTON, D.C., OFFICE, CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION

Mr. CUNNINGHAM. I am manager of the Washington, D.C., office, Christian Science Committee on Publication. On behalf of all the Christian Science churches and Christian Scientists in this country, which I represent, I wish to thank you for the opportunity to express the views of this church on H.R. 17550, the Social Security Amendments of 1970.

As you know, Christian Scientists rely exclusively on spiritual means through prayer for the prevention and cure of disease. When a Christian Scientist becomes sick, he turns to a Christian Science practitioner for help through prayer instead of to a physician. If nursing assistance is needed, he will seek out a Christian Science nurse. If institutional care is required, he will go to a Christian Science sanatorium.

On the whole, the medicare and medicaid programs, both of which include provisions for care in Christian Science sanatoriums, have been running smoothly as far as Christian Scientists are concerned.

However, there are some statutory problems which are potentially serious to us and to the programs.

Under section 1905(a)(15) of the Social Security Act and related regulations, States may include Christian Science sanatoriums in their title XIX plans. Like all institutions, these sanatoriums are required to be subject to State standard-setting authority by section 1902(a)(9). We do not think it proper to have States set standards for the care of patients in Christian Science facilities. We are glad, even anxious, to have States prescribe minimum levels for safety and sanitation and to inspect our buildings regularly from these standpoints. We would, therefore, be happy to be subject to section 1902(a)(9)(B) of the Social Security Act (p. 134 of the bill).

It must be understood, however, that Christian Science treatment is quite basically different from medical treatment and cannot be measured by medical criteria. Moreover, the States do not seem to wish to get involved in examining a kind of nursing care which is meaningful only as an auxiliary to religious healing.

In recognition of the peculiar situation States would find in trying to set standards for the care of patients who are institutionalized while seeking religious healing, the House Committee on Ways and Means included section 253(a) in the bill to exempt Christian Science sanatoriums from certain institutional requirements under the medicaid program. The Ways and Means Committee, however, was under the impression that our sanatoriums are considered "skilled nursing homes" under title XIX and therefore made the exemption broader than was necessary. The language of the bill also results in our sanatoriums being treated as "skilled nursing homes," and thus puts them in a part of the program which would compel nearly every State, whether it wishes to do so or not, to pay for care of medicaid patients in Christian Science sanatoriums. We do not believe the States should be forced to include Christian Science sanatorium care as a compulsory benefit under title XIX and therefore suggest that section 253(a) be amended to read as set forth in our full statement.

Mr. Chairman, this is one instance of where an organization asks to be taken out of something rather than to be included, but we feel that we should have the opportunity to work these things out on the State level and not have the Federal Government force a State to include us in the program if the State does not wish to do so.

As you know, the Socal Security Amendment of 1967 contained a new requirement that every State with an approved plan under title XIX must license all nursing home administrators. The rule applies to the administrators of all facilities defined as nursing homes under State law, including those which are not participating in the medicaid program. In some States our sanatoriums are licensed as nursing homes.

The States have been and are now in process of setting up nursing home administrator licensing requirements which, in many cases, include course work in principles of medical care, psychology, pharmacology, et cetera. License applicants will be examined on such matters as anatomy and physiology, materia medica, the aging process, and the administration of drugs.

A Christian Scientist would have deep and grave misgivings of conscience about involving himself in such matters. If he refused to

take the courses or tests and the present nursing home administrator statute were enforced, either the Christian Science sanatorium he administered would be forced to close or Federal medicaid funds to the entire State would be cut off. This would be true even if the sanatorium had no relationship to medicare or medicaid.

We do not believe the Federal Government should compel the States to license the directors of this unique type of institution, and we do not think Congress ever intended that administrators of nonmedical facilities should be required to demonstrate proficiency in medical subjects. The House agreed with this position and has added section 253(b) to exempt Christian Science sanatorium administrators from being licensed. We believe this provision should be retained without change?

The social security bill proposes to make medicare and medicaid reimbursements based on expenditures for plant and equipment conditional on conformity of those expenditures with an overall State plan developed under the Partnership for Health amendments. Any new or expanded health care facility which does not comply with the plan will not be allowed to consider depreciation of the plant as an element of reasonable cost to the extent of unplanned expenditures.

This seems a reasonable approach to controlling excessive or overlapping expansion, but it would not work for Christian Science sanatoriums, because the legislation establishing comprehensive health planning did not embrace these facilities. The House report on the bill creating the planning program states, "* * * a facility such as those provided by the Christian Science Church, relying solely on spiritual means through prayer for healing, would not be included as a health care facility within the meaning of this program" (H. Rept. 538, 90th Cong., p. 21).

Thus our institutions are in the anomalous situation of being excluded from State planning, but included in the medicare and medicaid programs. We believe that the rationale which led Congress to leave these sanatoriums out of State planning programs should extend to excluding them from any penalty for not complying with State plans.

The House has seen fit to provide an exemption for Christian Science sanatoriums in section 1122(h) of the Social Security Act (p. 87 of the bill). We believe this subsection should also be retained as it is.

S. 4101, a bill to create a Federal Child Care Corporation, has been introduced by yourself, Mr. Chairman, to help provide care for children of working parents. Although this bill is not the subject of the current hearings, it will amend the Social Security Act by adding a title XX, and therefore we think it appropriate to comment briefly at this point on S. 4101. In our full statement we explain that Christian Science children and staff members would have grave difficulty participating in this program unless they had some concrete assurance that they would not be compelled to accept medical examinations, immunizations, physical evaluations or treatment contrary to their religious beliefs.

Our statement offers two amendments to the Child Care Corporation Act, which we think states clearly the prevailing Government policy in this sort of situation.

The CHAIRMAN. May I say to you, sir, that that is perfectly all right with me. I have complete respect for Christian Scientists. I don't practice it myself. I have all the admiration in the world for people who do. They are devout. They believe in what they are doing, and I don't know what more you can expect of people than that they do what is right as the good Lord gives them the right to see it.

Mr. CUNNINGHAM. We certainly appreciate those thoughts and comments, Mr. Chairman. We are a denomination now of over 104 years, we are not just something that started a few decades ago. I think we have proven ourselves over the last century, and we are very grateful that the Congress, the Government, and especially the Senate Finance Committee, have recognized our particular situation in regard to our inclusion in various Federal programs, and for this we are very grateful.

Of course, under the Child Care Corporation Act, if a serious threat to the public health is involved, such as an epidemic, Christian Scientists would willingly consent to procedures considered medically necessary to protect others. But we always prefer to take care of our health in the way taught by our religion.

We have great respect for other methods of healing. We never try to insist upon our method to anyone, and if occasions occur where there are epidemics, although we feel that our method of treatment protects us, and since we are protected, others would be, we recognize that this is not realized by everyone, and we then submit to any form of immunization or any particular medical program that is set up in regard to epidemics, such as being isolated, so that our friends, or neighbors, the general public will have that sense of protection.

It is out of our love for our fellow human beings that we do this, and this sort of particular provision has been expressed in the exemptions which we have asked for. We will be most happy to discuss with your staff how the purposes of our suggested amendments might best be achieved within the framework of the Child Care Corporation Act.

We do not know, of course, at this time whether the substance of Senate 4101 will be added to the Social Security Act or whether it will be in the family assistance plan or whether it will be a combination of both, but we felt it important to us to bring it to your attention.

(The prepared statement of Mr. Cunningham follows. Hearing continues on page 609.)

STATEMENT OF THE CHRISTIAN SCIENCE CHURCH—PRESENTED BY C. ROSS CUNNINGHAM, MANAGER OF THE WASHINGTON, D.C. OFFICE, CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION

SUMMARY

The Christian Science Church, with respect to H.R. 17550:

1. Favors specific exemption of Christian Science sanatoriums from the requirement of state standards of patient care in Title XIX. New language is suggested to change section 253(a).

2. Requests that states be permitted to exempt Christian Science sanatoriums from the administrator licensing requirement of section 1908. Section 253(b) should be retained without change.

3. Asks that Christian Science sanatoriums, which are not deemed to be health care facilities for the purpose of the state health planning provision of the Public

Health Service Act, be permitted to receive depreciation payments under Medicare. Section 1122(h) of the Social Security Act, which appears in section 221(a) of the bill, should also be retained as it is.

4. Proposes that if the Federal Child Care Corporation Act is added to the Social Security Act, a provision be included recognizing the religious rights of Christian Science children and staff members.

STATEMENT

Mr. Chairman and Members of the Committee: My name is C. Ross Cunningham. I am Manager of the Washington, D.C. Office, Christian Science Committee on Publication. On behalf of all the Christian Science churches and Christian Scientists in this country, which I represent, I wish to thank you for the opportunity to express the views of this Church on H.R. 17550, the Social Security Amendments of 1970.

As you know, Christian Scientists rely exclusively on spiritual means through prayer for the prevention and cure of disease. When a Christian Scientist becomes sick, he turns to a Christian Science practitioner for help through prayer instead of to a physician. If nursing assistance is needed, he will seek out a Christian Science nurse. If institutional care is required, he will go to a Christian Science sanatorium.

On the whole, the Medicare and Medicaid programs, both of which include provisions for care in Christian Science sanatoriums, have been running smoothly as far as Christian Scientists are concerned. However, there are some statutory problems which are potentially serious to us and to the programs.

Under section 1905(a) (15)of the Social Security Act and related regulations states may include Christian Science sanatoriums in their title XIX plans. Like all institutions, these sanatoriums are required to be subject to state standard-setting authority by section 1902(a)(9). We do not think it proper to have states set standards for the *care* of patients in Christian Science facilities. We are glad, even anxious, to have states prescribe minimum levels for safety and sanitation and to inspect our buildings regularly from these standpoints. We would, therefore, be happy to be subject to section 1902(a) (9) (B) of the Social Security Act (page 134 of the bill). It must be understood, however, that Christian Science treatment is quite basically different from medical treatment and cannot be measured by medical criteria. Moreover, the states do not seem to wish to get involved in examining a kind of nursing care which is meaningful only as an auxiliary to religous healing.

In recognition of the peculiar situation states would find in trying to set standards for the care of patients who are institutionalized while seeking religious healing, the House Committee on Ways and Means included section 253(a) in the bill to exempt Christian Science sanatoriums from certain institutional requirements under the Medicaid program. The Ways and Means Committee, however, was under the impression that our sanatoriums are considered "skilled nursing homes" under title XIX and therefore made the exemption broader than was necessary. The language of the bill also results in our sanatoriums being treated as "skilled nursing homes," and thus puts them in a part of the program which would compel nearly every state, whether it wishes to do so or not, to pay for care of Medicaid patients in Christian Science sanatoriums. We do not believe the states should be forced to include Christian Science sanatorium care as a compulsory benefit under title XIX and therefore suggest that section 253(a) be amended to read as follows:

"Section 253. (a) Section 1902(a) of the Social Security Act is amended by adding at the end thereof the following new sentence:—

'The provisions of paragraphs 9(A), 29, and 32 shall not apply to Christian Science sanatoriums operated, or listed and certified, by The First Church of Christ, Scientist, in Boston, Massachusetts.' "

LICENSING OF CHRISTIAN SCIENCE SANATORIUM ADMINISTRATORS

As you know, the Social Security Amendments of 1967 contained a new requirement that every state with an approved plan under title XIX must license all nursing home administrators. The rule applies to the administrators of all facilities defined as nursing homes under state law, including those which are not participating in the Medicaid program. In some states our sanatoriums are licensed as nursing homes.

The states have been and are now in process of setting up nursing home administrator licensing requirements which, in many cases, include course work in principles of medical care, psychology, pharmacology, etc. License applicants will be examined on such matters as anatomy and physiology, materia medica, the aging process, and the administration of drugs.

A Christian Scientist would have deep and grave misgivings of conscience about involving himself in such matters. If he refused to take the courses or tests and the present nursing home administrator statute were enforced, either the Christian Science sanatorium he administered would be forced to close or Federal Medicaid funds to the entire state would be cut off. This would be true even if the sanatorium had no relationship to Medicare or Medicaid.

We do not believe the Federal government should compel the states to license the directors of this unique type of institution, and we do not think Congress ever intended that administrators of non-medical facilities should be required to demonstrate proficiency in medical subjects. The House agreed with this position and has added section 253(b) to exempt Christian Science sanatorium administrators from being licensed. We believe this provision should be retained without change.

The Social Security bill proposes to make Medicare and Medicaid reimbursements based on expenditures for plant and equipment conditional on conformity of those expenditures with an overall state plan developed under the Partnership for Health Amendments. Any new or expanded health care facility which does not comply with the plan will not be allowed to consider depreciation of the plant as an element of reasonable cost to the extent of unplanned expenditures.

This seems a reasonable approach to controlling excessive or overlapping expansion, but it would not work for Christian Science sanatoriums, because the legislation establishing comprehensive health planning did not embrace these facilities. The House Report on the bill creating the planning program states, ". . . a facility such as those provided by the Christian Science Church, relying solely on spiritual means through prayer for healing, would not be included as a health care facility within the meaning of this program" (House Report No. 538, 90th Congress, p. 21).

Thus our institutions are in the anomalous situation of being excluded from state planning, but included in the Medicare and Medicaid programs. We believe that the rationale which led Congress to leave these sanatoriums out of state planning programs should extend to excluding them from any penalty for not complying with state plans.

The House has seen fit to provide an exemption for Christian Science sanatoriums in section 1122(h) of the Social Security Act (page 87 of the bill). We believe this subsection should also be retained as it is.

S. 4101, a bill to create a Federal Child Care Corporation, has been introduced by Chairman Long of this Committee to help provide care for children of working parents. Although this bill is not the subject of the current hearings, it will amend the Social Security Act by adding a title XX, and therefore we think it appropriate to comment briefly at this point on S. 4101.

The Federal Child Care Corporation Act sets high standards for child care facilities and their operations, among which are some designed to protect the health of children using the Corporation's facilities. The way the Act is presently worded, however, parents who are Christian Scientists would have grave problems about entering their children in a facility under the program. We do not object to any standards aimed at preserving the health of those who choose medical methods of health protection, nor do we object to standards to protect groups of children from epidemics of communicable diseases. At the same time, however, we believe the Act should include a statement which would adequately preserve the religious rights of those who rely exclusively on spiritual means through prayer for the protection of their health, as Christian Scientists do.

Christian Scientists have had broad experience with this type of health provision as it affects children in the public schools of the fifty States. Thirty seven states have laws requiring immunization against one or more diseases, and nearly all of these exempt Christian Scientists from immunization requirements. We would be glad to furnish you with specific data on state vaccination and immunization laws, if you would find it helpful. Whereas most children are protected against a disease by medical immunization, Christian Science children are protected through our own method of treatment. Also, according to medical opinion, those who have not been medically immunized cannot transmit the disease to those who have been immunized.

Christian Scientists would also have difficulty in serving as staff members of child care facilities unless the program acknowledges their right to govern their own health care, with due consideration for the public health. We ask only that the administrators of the program be instructed to recognize our individual religious rights, and are quite willing to work with them on more specific regulations of staff health requirements.

The Congress has traditionally exempted persons with religious objections from immunization and treatment in situations like this. For instance, the Vaccination Assistance Act (Public Law 87–868) clearly exempts persons who choose to decline vaccination, and the Social Security Act itself contains two sections (515 and 1907) which make it clear that the health benefits in titles V and XIX are voluntary. In the present Congress the Senate has made two exemptions in similar programs at our request. S. 2264, The Communicable Disease Control and Vaccination Assistance Amendments of 1969, which has passed the Senate and extends the provisions of Public Law 87–868, again states that the immunization provided for in the Act may be declined by any individual. S. 3648, the District of Columbia Health Improvement Act, which was enacted by the Senate on July 30, 1970, provides:

"Sec. 303. No vaccination, immunization, or tuberculin test shall be required of any child whose parent or guardian objects thereto in writing on grounds that such vaccination, immunization, or tuberculin test is contrary to his religious teachings and practices."

Thus, by specifically recognizing the religious rights of children who prefer not to undergo medical examination, treatment, etc., you would merely be conforming the Child Care Corporation Act to existing Federal statutes and policies.

In an effort to clarify these points in your bill, we suggest the following amendments to section 2004(d) (1) and (5):

Delete the semicolon at the end of sec. 2004(d) (1), page 9 line 22, and add:

"provided, however, that no child seeking to enter or receiving care shall be required to undergo any medical examination, immunization, physical evaluation or treatment (except to the extent necessary to protect the public from epidemics of contagious diseases) if his parent or guardian objects thereto in writing on religious grounds;"

Delete the semicolon at the end of sec. 2004(d) (5), page 10 line 14, and add:

"provided, however, that any rules and regulations involving medical examination, immunization, or physical evaluation of staff members of such facility shall include appropriate exemptions (with due consideration to the protection of the public from epidemics of contagious diseases) for those who object thereto on religious grounds."

We will be most happy to discuss with your staff how the purposes of our suggested amendments might best be achieved within the framework of the Child Care Corporation Act. We do not know, of course, at this time whether the substance of S. 4101 will be added to the Social Security Act Amendments of 1970.

In closing let us thank you for the consideration this Committee has always given us as well as for this opportunity to testify. The main thing to remember is that we seek legislative changes not to advance our denomination, but because of the hundreds of thousands of sincere citizens seeking to practice their deeply-felt religious convictions in freedom and at the same time participate in and support the social progress represented by these programs. We believe that the suggestions made in this statement can only improve the programs they are addressed to, and will not weaken them in any way.

The CHAIRMAN. Mr. Cunningham, just for the record, I would like to ask you a question.

Mr. CUNNINGHAM. Of course.

The CHAIRMAN. Please understand I totally and completely respect the views of the Christian Scientists and for all I know you might be 100 percent right and everybody who goes to a doctor might be a hundred percent wrong. I am not going to quarrel about that because——

Mr. CUNNINGHAM. We won't argue either.

The CHAIRMAN. Because you can't very well argue with a man about his religion, and if he really believes that by not taking medicine his chances of surviving are better or if he thinks that if the good Lord

wants to call him home he shouldn't interfere with that decision on the part of the Deity, that is his privilege.

But now, just what is your reaction to a situation where a person has a bacterial infection for which you have a drug that is supposed to give him a good chance of surviving. Let's take pneumonia. If he has a serious infection of pneumonia, medical science would contend that you would give him an antibiotic and it would improve his chances of surviving by two or three times over what it would be if you didn't give it to him.

Now I know Christian Science would advocate he should not take that medicine and not call that doctor. What is your argument when the percentages would indicate that medicine would help the person?

Mr. CUNNINGHAM. Well, we firmly believe, Senator, that a situation like that, first of all, should not be ignored, that something has to be done, that treatment must be given.

Our treatment, though, is different. It has often been said that we don't take medicine. However, we do, but our medicine is of a different type. Our medicine is prayer, and we take doses of medicine constantly, but it is prayer.

It has also been said that we don't go to a physician. We do, but our physician is God, and we go to him constantly. So we, through our religion, through our understanding of what God, man, and their relationship is, would pray and take the medicine which to us would be the most effective in the world.

We could discuss this at some length and point out various things from the Bible which we feel sets this forth in the founding of the Christian religion. We could quote you statistics to the *n*th degree as to instances where Christian Science has healed cases where materia medica has given up.

In fact, most of the people when the Christian Science religion first started, most of those who became scientists did so because Christian Science healed them after materia medica couldn't. So we would say that if a person had an illness such as you described, they must do something. In other words, this is not to be ignored. It isn't, you see, that we refuse medicine or refuse doctors. It is that we prefer to use our method of medicine and to go to our physician. This is the whole difference.

The CHAIRMAN. Now, I did want to ask about this matter.

Mr. CUNNINGHAM. Yes.

The CHAIRMAN. It is costing a fairly substantial amount in some of our Christian Science sanatoriums. For example, we are paying as much as $70 a day for care in a Christian Science sanatorium and that is as much as we pay in some hospitals where they are administering a lot of services that your people do not advocate.

Now, why would the cost be so much, $70 a day?

Mr. CUNNINGHAM. I think I know the sanatorium which you may be referring to.

The CHAIRMAN. Actually there are several.

Mr. CUNNINGHAM. Well, there is one currently, at least within the last year. But also in those figures, of course, it will show up there are some that are charging no more than $25, $30, and such figures as that.

The one that is charging, that has at least submitted bills that are so high is because of a peculiar situation, and I think maybe you are

referring to High Ridge House in Bedford Hills. Is that in New York?

The CHAIRMAN. Well, there are several here; Broadview at Los Angeles, Christian Science at San Francisco, Concord House in Detroit, High Ridge at New York.

Mr. CUNNINGHAM. All right. I can, if you would like and you want to take the time, go over and discuss them one by one or if you would prefer we can discuss them with the staff.

The CHAIRMAN. Here is one Canterberry Crest at Tigard, Oreg. Their daily cost is $95.

Mr. CUNNINGHAM. Well, that, of course, was unaudited and is unpaid. Well, the thing that happened there, it went from $95 down to $40 but there were only four patients.

The CHAIRMAN. All I would like generally——

Mr. CUNNINGHAM. For the whole year.

The CHAIRMAN. I just want to get some indication as to what services they perform in these Christian Science sanatoriums which cause these charges to be quite high in some cases. They are not doing the same things that are done in other hospitals. What is it they are doing that is costing this much money?

Mr. CUNNINGHAM. In some cases admittedly our costs have been high and we have been attempting in every way to get them down. For instance, in one sanatorium by changing administrators, getting someone who was far more knowledgeable and proficient in the work, the costs were reduced 25 to 30 percent. However, we do have certain built-in costs that are a little different from hospitals. For instance, each patient is in a private room, and this is due to the fact that the method of treatment, which is purely religious, purely through prayer very frankly it is difficult to be given if there are a great number of people around. In other words, you take your problem to God in private, and work it out individually and with the help of a practitioner in private.

Also it must be realized that our sanatoriums are considered both as hospitals and extended care facilities. So this sometimes increases medicare costs in a way not present in a medical institution.

The CHAIRMAN. We also have this other problem; the length of of stay runs longer.

Mr. CUNNINGHAM. Yes, this is true.

The CHAIRMAN. For example, the length of stay runs anywhere from two to four times as long as the average stay we are paying for in hospitals and the reason for that is—mind you, please understand I am not here to quarrel with you.

Mr. CUNNINGHAM. I know that.

The CHAIRMAN. I would just like to raise this question. In view of the fact that your approach is different and your treatment is different and the length of stay is different, why don't we consider an entirely separate type of arrangement for the Christian Science sanatoriums than we do for the medical hospitals—handle them on an entirely different basis.

Mr. CUNNINGHAM. Well, you do in many ways. You give us special recognition because of the different nature of our care.

Let me explain as to why perhaps our length of stay is a little longer. A Christian Scientist wouldn't be going to a sanatorium unless

it was a situation that he had not been able to work out at home, that required a certain amount of nursing care that couldn't be given at home.

For instance, someone might have an attack of appendicitis and it would be healed through Christian Science in a day or so. That person wouldn't have gone to a sanatorium and wouldn't have had the cost of sanatorium care.

The individuals who are scientists who go to sanatoriums are those who have problems that they haven't worked out yet, and so they are usually of a far more serious nature than someone who would be going to a medical institution.

So because of that, because of the nature of the problem, it seems that they stay there a longer period of time. However, proportionately we would judge that the number of Christian Scientists who go to one of our institutions is much less than the number of people who use medical treatment would go to a hospital. So although our people stay longer, we have fewer people going.

The CHAIRMAN. My thought is that in view of the fact that the approach of the Christian Scientists is entirely different from, the approach of those who go to medical hospitals, that perhaps we ought to work out some equitable arrangement by which we determine what the pro rata share of the money would be and simply provide that for a program for Christian Science.

Mr. CUNNINGHAM. Well, this we would like to discuss with you first. It has many ramifications.

The system, as far as we are concerned, to date has worked very efficiently. We have some of our own built-in problems in the administering and the improving of our facilities which we are attempting to do, and I am grateful to say there has been much progress.

Also, as far as the rates are concerned in the study that was made, we would suggest that they really only consider the last 2 or 3 years because the method of reporting for 1966 and 1967 was entirely different. They asked us at one time to report everybody in the institutions. Then they decided, well, no, just everybody who would be entitled to medicare because of being 65 and over, so you have some very, well what looked like some very inconsistent figures as to the number of people admitted.

Regarding the rates, we have run into the same thing as other care facilities in that our costs are going up, hopefully not as much proportionately as the medical institutions. We are doing everything that we can. We have a department of care which constantly goes around the country making sure that our institutions are run to our high standards, that the administrators are following the various procedures set forth by the department of care, and we do everything we possibly can to bring these up to the very best care facility of its type that we can.

The CHAIRMAN. We might try to work out a type program tailored to fit the Christian Science religion rather than the one designed to fit the medical practice, and if we do it might help solve your problems and also help solve ours.

Mr. CUNNINGHAM. This could be because the program is tailored for medical institutions, and since it is directed that way then we have

to get exemptions and special considerations and so forth from the law which, as usually written, covers all care institutions.

Maybe there should be some special section of the medical bill that would say Christian Science sanatoriums are a part of it, and set forth their particular approach in a way that wouldn't intrude upon the medical method of treatment, and we wouldn't be interfered with by just general laws and regulations that could by interpretation impede our method of treatment.

The CHAIRMAN. Well, thank you very much, Mr. Cunningham.

If there is something more you want to add, I suppose you might summarize that. I think you have made a good statement.

Mr. CUNNINGHAM. Well, I would just like to thank you for the consideration the committee has always given us. I think the main thing to remember is that we seek legislative changes not to advance our denomination, but because of the hundreds of thousands of sincere citizens seeking to practice their deeply felt religious convictions in freedom and, at the same time, participate in and support the social progress represented by these programs. We feel they are excellent programs, and we believe that the suggestions made in the statement can only improve the programs they are addressed to and won't weaken them in any way. We are always grateful to have the opportunity to appear before you.

The CHAIRMAN. The next witness is Dr. V. Eugene McCrary, Cunningham.

Mr. CUNNINGHAM. Thank you.

The CHAIRMAN. The next witness is Dr. V. Eugene McCrary, chairman, Committee on Federal Legislation, American Optometric Association, accompanied by Dr. Harold F. Demmer, consultant on social security to the Division of National Affairs, Richard W. Averill, director, Division of National Affairs, and Donald F. Lavanty, director of federal legislation.

We are pleased to welcome you, Dr. McCrary.

STATEMENT OF DR. V. EUGENE McCRARY, CHAIRMAN, COMMITTEE ON FEDERAL LEGISLATION, AMERICAN OPTOMETRIC ASSOCIATION; ACCOMPANIED BY DR. HAROLD F. DEMMER, CONSULTANT ON SOCIAL SECURITY TO THE DIVISION OF NATIONAL AFFAIRS; RICHARD W. AVERILL, DIRECTOR, DIVISION OF NATIONAL AFFAIRS; AND DONALD F. LAVANTY, DIRECTOR OF FEDERAL LEGISLATION

Dr. McCRARY. Thank you, Mr. Chairman.

Mr. Chairman and distinguished members of the committee, I am Dr. V. Eugene McCrary, an optometrist actively engaged in private practice in College Park, Md. I am chairman of the American Optometric Association Committee on Federal Legislation, and a past president of the AOA. To conserve your time, a brief biographical sketch is attached to my statement.

Accompanying me today are Dr. Harold Demmer, an optometrist from Houma, La.; Richard W. Averill, director of the AOA Washington office; and Donald F. Lavanty, staff director of Federal Legislation in the Washington office. Dr. Demmer is a special consultant

on social security for the AOA Division of National Affairs; Mr. Averill holds the juris doctor degree from American University; and Mr. Lavanty was awarded the L.L.B. degree from George Washington University.

I realize, Mr. Chairman, we are pressed for time in these hearings and I would like the privilege at this point of inserting the statement into the record as we have it prepared and also to insert a second statement dealing with the topic of Peer Review.

The CHAIRMAN. Yes, that will be done.

Dr. McCRARY. Thank you. I will excerpt certain parts from the prepared statement.

The CHAIRMAN. Please do that.

(The documents referred to follow. Hearing continues on page 619.)

STATEMENT OF V. EUGENE McCRARY, O.D., FOR THE AMERICAN OPTOMETRIC ASSOCIATION

INTRODUCTION

Mr. Chairman and distinguished members of the Committee: Thank you for the opportunity of appearing here today.

I am Doctor V. Eugene McCrary, an optometrist actively engaged in private practice in College Park, Maryland. I am Chairman of the American Optometric Association Committee on Federal Legislation, and a Past President of the AOA. To conserve your time, a brief biographical sketch is attached to my statement.

Accompanying me today are Doctor Harold Demmer, an optometrist from Houma, Louisiana; Richard W. Averill, Director of the AOA Washington Office; and Donald F. Lavanty, Staff Director of Federal Legislation in the Washington Office. Doctor Demmer is a special consultant on Social Security for the AOA Division of National Affairs; Mr. Averill holds the Juris Doctor degree from American University; and Mr. Lavanty was awarded the L.L.B. degree from George Washington University.

THE AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association is a federation of 51 optometric societies or associations representing all the States and the District of Columbia. Present membership in the organization is 15,480.

ASSOCIATION SUPPORTS S. 1402

"Americans of age 65 and over—though drawing substantial, essential economic assistance from Medicare, and to a much lesser extent, from Medicaid—nevertheless continue to be the major victims of unresolved problems related to the costs, quality and availability of medical care in the United States today."

That statement, contained in an Advisory Committee report for the Senate Special Committee on Aging, broadly encompasses the problem I wish to bring to your attention today.

One of the unresolved problems in the provision of health care to Medicare beneficiaries is the lack of availability of vision care and convenient access to over 17,000 optometrists specifically educated and State-licensed to provide such care.

The lack of access to optometrists and their services constitutes, at the least, an inconvenience to Medicare beneficiaries who need allowable eye care services. The language of Title XVIII of the Social Security Act requires them to seek eye care from a physician skilled in diseases of the eye. For those beneficiaries who have elected for many years to obtain vision care from optometrists, the present language of Section 1861(r) constitutes a serious inequity: the beneficiary is denied his free choice of eye care practitioner.

The House Ways and Means Committee addressed this matter in its recent Report 91-1096 on the legislation you are considering. Page 66 of the Report contains the following statement:

". . . the Medicare provisions as related to optometrists may need revision in that some optometric services when provided by a physician are covered, but may not be covered when provided by an optometrist."

These services include prescribing and fitting of post-cataract contact lenses and eyeglasses and services which are incidental to such prescribing and fitting, and the fitting of artifical eyes as provided for under the present provisions of Title XVIII.

The Report also stated that the Department of Health, Education, and Welfare should "submit language . . . designed to remove any existing inequity."

Adoption of S. 1402 would be an adequate solution to the problem. That bill would, clearly and simply, include an optometrist in the definition of "physician" under Section 1861(r) of Title XVIII by addition of the following subparagraph:

"(4) a doctor of optometry, but only with respect to functions which he is legally authorized to perform by the State in which he performs them."

This language is familiar to most of you on the Committee, for it is the same language approved by this Committee and subsequently adopted by the Senate when amendments to Medicare were considered in 1967. At that time, however, the House conferees did not concur.

Adoption of this amendment to 1861(r) would not increase costs because the allowable services would remain as they are. There would be no broadening of the services available. Addition of the language proposed by S. 1402 would only serve to remove the existing inequities which create unnecessary hardships for Medicare beneficiaries, and would make presently allowable services more conveniently available to them.

Inclusion of optometrists under Section 1861(r) would permit optometrists to certify the need for such services and provide services which are optometric in character for which other practitioners are currently being reimbursed.

AVAILABILITY OF CARE; GEOGRAPHICAL DISTRIBUTION OF OPTOMETRISTS

An Advisory Committee to the Senate Special Committee on Aging found that 39% of all persons age 65 or over reside in nonmetropolitan areas. This means that between one third and one half of all Medicare beneficiaries may be subjected to the personal inconvenience, unnecessary expense, and potential physical hardship which constitute major barriers to prompt eye care under the present provisions of 1861(r).

The inclusion of optometrists under 1861(r) would eliminate the need for Medicare eligibles to travel to metropolitan areas for allowable eye care services. Optometric care is available in 5,438 cities and towns of all sizes throughout these United States.

UTILIZATION OF HEALTH MANPOWER

Congress has repeatedly expressed its recognition of the growing shortage of all health manpower and has enacted new programs specifically for the education of optometrists and other health professionals. So long as a shortage exists, it is especially important that all health manpower be utilized effectively.

Full utilization of the skills of optometrists for eye care services under Medicare would result in the most prompt attention possible for the beneficiaries who need allowable services optometrists can provide. Many times the delay in treatment caused by an inordinate amount of time for transportation can have serious and preventable consequences. This works against the best interests of the patient. Providing access to the services of optometrists would, at the same time, restore the beneficiaries' freedom to choose whatever eye care practitioners they may select.

CONGRESSIONAL AND OTHER FEDERAL RECOGNITION OF OPTOMETRY

Both the Congress and the Department of Health, Education, and Welfare have determined that optometric vision care is a vital component in the Nation's health care system.

Optometry is one of the five primary independent health professions eligible for Federal support of its schools and colleges under the Health Professions Educational Assistance Act of 1963 as amended in 1965 and included in the Health Manpower Act of 1968. The other independent health care professions

which qualify for such assistance are medicine, osteopathic medicine, dentistry, and podiatry, all of which are included in Section 1861(r) of Title XVIII.

The Federal government has a large investment in schools and colleges of optometry, under programs approved by the Congress to educate and graduate more optometrists and make their services available to the public. It is inconceivable that the Congress really intended that beneficiaries of Federally-funded health care delivery programs such as Medicare should be denied access to those very practitioners the Federal government has helped to educate.

Inclusion of optometry in the Health Professions Educational Assistance Act is by no means the only manifestation of Congressional recognition accorded optometry. Legislation making specific provisions for optometry in Federal programs includes the Vocational Rehabilitation Act of 1968; the Allied Health Professions Assistance Act; Title XI, National Housing Act, providing for Federally guaranteed financing for construction of group practice facilities including optometric care; Titles II, V, X, XVI, and XIX of the Social Security Act; the Highway Safety Act of 1966; the Medical Libraries Assistance Act; and others.

Various departments, agencies, and bureaus of the Federal government recognize and utilize the services of optometrists. There are, today, over 600 optometrists on active duty in the Armed Services; a number of optometrists are pursuing their optometric careers as members of the Public Health Service Commissioned Corps; and nearly 40 optometrists are assigned today as consultants to such Federal programs as Project Head Start, the Public Health Service Division of Indian Health, the Peace Corps, the Civil Service Commission, the Veterans Administration, the Office of Emergency Preparedness, and others.

It certainly seems to us highly inconsistent that the Congress on one hand fully recognizes optometry as a profession yet for purposes of the Medicare program effectively bars the access of beneficiaries to the care optometrists are educated and licensed to provide.

Recognition of the importance of prompt optometric care for dependents of military personnel is evidenced by a recent directive concerning the "military Medicare" program, formally known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Although routine eye examinations and ordinary spectacles are not authorized under the CAMPUS program, regulations under 5–2–L provide for "special lenses or contact lenses for those eye conditions which will require these items for complete medical or surgical management of the condition. Also, eye examinations performed by an ophathalmologist or doctor of optometry for the purpose of ruling out a pathological condition."

The Selective Service System grants optometry students II–S deferments for completion of their four year professional degree courses, and drafts optometrists only under the "Doctor's Draft," to which they are subject until age 35. The only other health care professions whose practitioners have been drafted under provisions of the Doctor's Draft are doctors of medicine, doctors of osteopathy, dentists, and veterinarians.

Proposed legislation to establish a system of National Health Insurance also shows the intent of many members of both the Senate and House of Representatives to assure that Americans covered by National Health Insurance have the freedom to choose either an optometrist or physician skilled in diseases of the eye when allowable services are required by the beneficiary. S. 4297, introduced by Senator Edward Kennedy with co-sponsorship of 18 other Senators, specifically designates optometrists as providers of optometric services. Representative Martha Griffiths, author of H.R. 17806 proposing a National Health Insurance plan, has stated: "It is my intention to cover optometrists, in the final drafting of the bill, either by defining them as referral physicians or primary physicians."

AMERICAN OPTOMETRIC ASOCIATION POSITION ON SENATE AMENDMENT # 756

Senate Amendment # 756 incorporates the provisions of S. 1896, a bill introduced earlier by Senator Vance Hartke, to extend medicare services to include provision of drugs, routine eye care and eyeglasses, routine dental services, dentures, and hearing aids. All of those items are of great importance to medicare beneficiaries. Those items and services, while not increasing in cost as rapidly as general health and hopsital care, can create worrisome financial problems for individuals in the 65-and-over age group who must live on fixed incomes.

Senate Report 91–875, a Report of the Special Committee on Aging which I mentioned earlier, touches on this problem. Page 29 of the Report contains this paragraph:

"Other Non-Covered Needs—Medicare does not now cover dental, foot and eye care, eyeglasses, hearing aids and most types of medical appliances. In addition, there are limitations on the length of stay in a hospital or nursing home and the number of home health visits which are paid for. 'These (including prescription drugs) are the principle limitations which require the elderly even under medicare to meet more than half of their health care costs,' said Advisory Committee member Bert Seidman."

It is the fervent hope of the American Optometric Association that these items can and will be included under medicare, for optometric care will enrich the quality of life for Title XVIII recipients. The time has arrived when the Congress and all components of the health care system can no longer deny the existence of vision care as a primary health need rather than as an auxiliary, supplemental or "incidental" health service. Those who are eligible for health benefits under the medicare program want and need visions care services.

A recent publication, "The Golden Years: a Tarnished Myth," prepared for the Office of Economic Opportunity by the National Council on the Aging, states (on page 147): "Within the context of the existing Medicare program, the following are the most desirable extensions from the point of view of the older poor, and they are recommended to the Congress: 1) coverage for prescription drugs, out of the hospital; 2) dental care, including dentures; 3) eye care, including eyeglasses. . . ." and three other items. The study conducted by the National Council on the Aging showed that poor vision ranked first among the major symptomatic complaints of individuals identified in the study as poor or near poor. In the group identified as "poor", 68% of those in the study said poor vision was their greatest complaint; among the "near poor", 58% rated poor vision as their major complaint. This is but one more convincing bit of evidence, developed at Federal government expense, of the need for making professional vision care conveniently available to the elderly in America.

In testimony presented by the American Optometric Association before the House Ways and Means Committee last October, we presented a basic plan complete with estimated costs, whereby Medicare beneficiaries would receive a complete vision examination and evaluation every two years. The beneficiaries would assume the responsibility for obtaining whatever ophthalmic devices which might be required. Because preventive health care of this type reduces the need for more drastic medical correction at some later date, it can be expected that the total cost per patient covered might be less over the years than experienced under the present system.

Mr. Chairman, we feel that periodic complete vision evaluations are a "must" for our senior citizens under Medicare. We support the concept that such vision care should be provided at the earliest moment Congress finds it economically feasible.

SUMMARY AND RECOMMENDATIONS

For the reasons we have outlined, Mr. Chairman, the American Optometric Association urges that the Senate adopt, as it did in the 90th Congress, an amendment to include a doctor of optometry in Section 1861(r) of Title XVIII.

Adoption of S. 1402 would permit the beneficiary to go directly to the physician or optometrist of his choice.

Adoption of S. 1402 would avoid the additional delay and expense created by the present requirement that a physician must certify the "medical need" of a beneficiary to consult an eye care specialist.

Adoption of S. 1402 would not alter the mode of practice of optometrists or physicians; neither would it conflict nor interfere in any way with State laws governing the practice of optometry or medicine.

Utilization of allowable eye care services would not necessarily be increased; rather, those beneficiaries requiring such allowable services would simply be able to obtain them with less difficulty. This, it seems to us, is a reasonable and valid expectation and is in accord with the spirit and intent of the law.

On behalf of the American Optometric Association, I thank you for your time and attention. Now, if you have any questions, Dr. Demmer, Mr. Averill, Mr. Lavanty and I would be happy to attempt to respond to them.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION ON SENATE AMENDMENT NO. 851 TO H.R. 17550

Mr. Chairman and members of the Committee: The American Optometric Association is deeply concerned about the possible effects of adoption of Senate Amendment 851 proposed by Senator Bennett to improve those Sections of the Social Security Act which deal with professional standards review.

The American Optometric Association appreciates the praiseworthy motives of Senator Bennett evidenced by his desire to improve the professional standards review system, particularly with respect to Title XVIII and Title XIX programs.

Investigations and studies of programs under both Titles, conducted under the auspices of your Committee, have shown quite conclusively that more effective methods of review might have resulted in better health care services for beneficiaries of the Medicare and Medicaid programs and might also have saved considerable sums of taxpayer's money during the first four years the programs were operable. In light of your investigations and studies, it would appear that revision of the professional review system is justified.

It is not our intent to criticize the Congress nor the Executive branch for the weaknesses which have become apparent in the professional review system built into the original Medicare and Medicaid legislation. Quite on the contrary, we feel the initial approach to the problem of fair and orderly review was basically an outstanding first attempt to maintain quality services and create the necessary controls. We believe the Congress adopted the best system it was possible to devise without the benefit of several years' experience in operation of the Medicare and Medicaid programs.

Now that both programs have been operating for some time, the Social Security Administration and appropriate units of the Congress have available a considerable body of data on costs and the effectiveness of controls and systems originally included in the Medicare and Medicaid legislation. With this information available, it should now be possible to initiate general improvements in the professional standards review sections of Titles XVIII, XIX, and the other Titles of the Act which rely upon peer review for maximum efficiency.

It is disconcerting to note that the language of Senator Bennett's amendment, number 851, might have the effect of erroneously redefining "peer review" beyond recognition of the term as it is understood today by the Congress, the Executive Branch, and the health care practitioners whose performance is subject to review.

The very phrase "peer review" states succinctly the manner in which professional standards review must be conducted if it is to be feasible, fair, and fruitful. The phrase states—and simply means—that health care services provided by any given professional practitioner shall be reviewed by other health care professionals whose training and expertise are equal to those of the practitioner whose professional standards, ethics, performance and procedures are to be reviewed.

Optometrists cannot and should not be permitted nor required to judge the efficacy of treatment or patient management provided by a physician. Conversely, a physician who has no optometric education cannot and should not be permitted nor required to pass judgment on the efficacy of services provided by an optometrist.

Adoption of Amendment 851 in its present form would result in a situation where the performance of every health care practitioner—optometrist, dentist, osteopathic physician, or podiatrist—would be subject to professional standards review performed solely by doctors of medicine. This could in no way be considered "peer review", either by dictionary definition or common usage.

Well organized professional standards review mechanisms are readily available in every State for true peer review of the performance of practitioners within each of the health professions. Just as the present peer review mechanism provided by State medical societies is available for review of the performance of doctors of medicine, there is likewise such a State-level mechanism available, ready and willing to assume the responsibility for review of services provided by each of the other health professions. For example, each State and the District of Columbia has its own optometric society or association, through which an appropriate review system can readily be established. In fact, optometry's experience with such a system dates back to the early 1960's when a peer review system became necessary under the newly-enacted Kerr-Mills legislation, forerunner of today's Title XIX.

Each State society or association for each health care profession is keenly interested in providing the best possible health care service for every patient within the scope of that profession's licensing statutes; each is keenly sensitive to the need for maintaining high ethical standards of practice; each one is concerned with providing full value for each dollar invested by the Federal government and the taxpayer in delivery of quality health services. And each of these organizations accepts its responsibility to police its own membership firmly and fairly in administration of publicly financed or publicly assisted programs.

It is the hope of the American Optometric Association and its members that this Committee will accord each of the State societies of the health care professions the opportunity to assume their rightful roles in the conduct of professional standards review under Medicare and Medicaid.

The American Optometric Association agrees wholeheartedly with the concept of "peer review," and urges that it be strengthened as a valid and valuable management control within the Medicare and Medicaid programs. We urge that the professional standards review system be improved in such a manner as to carry out the basic intent of Senator Bennett's amendment.

Dr. McCrary. The American Optometric Association is a federation of 51 optometric societies or associations representing all the States and the District of Columbia. Present membership in the organization is 15,480.

One of the unresolved problems in the provision of health care to medicare beneficiaries is the lack of availability of vision care and convenient access to over 17,000 optometrists specifically educated and State-licensed to provide such care.

The lack of access to optometrists and their services constitutes, at the least, an inconvenience to medicare beneficiaries who need allowable eye care services. The language of title XVIII of the Social Security Act requires them to seek eye care from a physician skilled in diseases of the eye. For those beneficiaries who have elected for many years to obtain vision care from optometrists, the present language of section 1861(r) constitutes a serious inequity: the beneficiary is denied his free choice of eye care practitioner.

The House Ways and Means Committee addressed this matter in its recent Report 91-1096 on the legislation which is now being considered by this committee. Page 66 of that report contains the following statement, and I quote:

> . . . the medicare provisions as related to optometrists may need revision in that some optometric services when provided by a physician are covered, but may not be covered when provided by an optometrist.

Adoption of S. 1402 would be an adequate solution to the problem. That bill would, clearly and simply, include an optometrist in the definition of "physician" under section 1861(r) of title XVIII by addition of the following subparagraph:

> (4) a doctor of optometry, but only with respect to functions which he is legally authorized to perform by the State in which he performs them.

This language is familiar to most of you on the committee, for it is the same language approved by this committee and subsequently adopted by the Senate when amendments to medicare were considered in 1967. At that time, however, the House conferees did not concur.

Adoption of this amendment to 1861(r) would not increase costs because the allowable services would remain as they are. There would be no broadening of the services available. Addition of the language proposed by S. 1402 would only serve to remove the existing inequities which create unnecessary hardships for medicare beneficiaries,

and would make presently allowable services more conveniently available to them.

Inclusion of optometrists under section 1861(r) would permit optometrists to certify the need for such services and provide services which are optometric in character for which other practitioners are currently being reimbursed.

An advisory committee to the Senate Special Committee on Aging found that 39 percent of all persons age 65 or over reside in nonmetropolitan areas. This means that between one-third and one-half of all medicare beneficiaries may be subjected to the personal inconvenience, unnecessary expense, and potential physical hardship which constitute major barriers to prompt eye care under the present provisions of 1861(r). And I say that in relation to the accessibility of care.

It is our feeling that the inclusion of every optometrist under 1861 (r) would eliminate the need for medicare eligibles to travel to metropolitan areas and wait in long lines for allowable eye care services. Optometric care is available in 5,438 cities and towns of all sizes throughout these United States.

Congress has repeatedly expressed its recognition of the growing shortage of all health manpower and has enacted new programs specifically for the education of optometrists and other health professionals. So long as a shortage exists, it is especially important that all health manpower be utilized effectively.

Full utilization of the skills of optometrists for eye care services under medicare would result in the most prompt attention possible for the beneficiaries who need allowable services optometrists can provide. Many times the delay in treatment caused by an inordinate amount of time for transportation and waiting for appointment scheduling can have serious and preventable consequences. This works against the best interests of the patient. Providing access to the services of optometrists would, at the same time, restore the beneficiaries' freedom to choose whatever eye care practitioners they may select.

Both the Congress and the Department of Health, Education, and Welfare have determined that optometric vision care is a vital component in the Nation's total health care system.

Optometry is one of the five primary independent health professions eligible for Federal support of its schools and colleges under the Health Professions Educational Assistance Act of 1963 as amended in 1965 and included in the Health Manpower Act of 1968. The other indepedent health care professions which qualify for such assistance are medicine, osteopathic medicine, dentistry, and podiatry, all of which are included in section 1861(r) of title XVIII.

The Federal Government has a large investment in schools and colleges of optometry, under programs approved by the Congress to educate and graduate more optometrists and make their services available to the public. It is inconceivable that the Congress really intended that beneficiaries of federally-funded health care delivery programs such as medicare should be denied access to those very practitioners the Federal Government has helped to educate.

Inclusion of optometry in the Health Professions Educational Assistance Act is by no means the only manifestation of congressional recognition accorded optometry. Legislation making specific provisions for optometry and optometric services in Federal programs in-

cludes the Vocational Rehabilitation Act of 1968; the Allied Health Professions Assistance Act; Title XI, National Housing Act, providing for federally guaranteed financing for construction of group practice facilities including optometric care; Titles II, V, X, XVI, and XIX of the Social Security Act; the Highway Safety Act of 1966; the Medical Libraries Assistance Act; and others.

Various departments, agencies, and bureaus of the Federal Government recognize and utilize the services of optometrists. There are, today, over 600 optometrists serving on active duty in the armed services; a number of optometrists are pursuing their optometric careers as members of the Public Health Service Commissioned Corps' and nearly 40 optometrists are assigned today as consultants to such Fed-Division of Indian Health, the Peace Corps, the Civil Service eral programs as Project Headstart, the Public Health Service Commission, the Veterans Administration, the Office of Emergency Preparedness, and others.

It seems to us highly inconsistent that the Congress on one hand fully recognizes optometry as a profession and appropriates money to help build schools, yet for purposes of the medicare program effectively bars the access of beneficiaries to the care optometrists are educated and licensed to provide.

Recognition of the importance of prompt optometric care for dependents of military personnel is evidenced by a recent directive concerning the "military Medicare" program, formally known as the civilian health and medical program of the uniformed services (CHAMPUS). Although routine eye examinations and ordinary spectacles are not authorized under the CHAMPUS program, regulations under 5-2-L provide for "special lenses or contact lenses for those eye conditions which will require these items for complete medical or surgical management of the condition. Also, eye examinations performed by an opthalmologist or doctor of optometry for the purpose of ruling out a pathological condition."

The Selective Service System grants optometry students II-S deferments for completion of their 4-year professional degree courses, and drafts optometrists only under the "doctor's draft," to which they are subject through age 35. The only other health care professions whose practioners have been drafted under provisions of the doctor's draft are doctors of medicine, doctors of osteopathy, dentists, and veterinarians.

It is our firm conviction, Mr. Chairman, that vision care is a primary health need rather than an auxiliary, supplemental or incidental health service.

We feel that the time has arrived when Congress and all components of the the health care system should recognize this need. Those who are eligible for health benefits under the Medicare program want and need vision care services.

A study conducted by the National Council on the Aging showed that poor vision ranked first among the major symptomatic complaints of individuals identified as "poor," 68 percent of those in the study said poor vision was their greatest complaint; among the "near poor," 58 percent rated poor vision as their major complaint. This is but one more convincing bit of evidence, developed at Federal Govern-

ment expense, of the need for making professional vision care conveniently available to the elderly in America.

Mr. Chairman, we feel that periodic complete vision evaluations are a "must" for our senior citizens under medicare. We support the concept that such vision care should be provided at the earliest moment Congress finds it economically feasible.

Now, in summary, for the reasons we have outlined, Mr. Chairman, the American Optometric Association urges that the Senate adopt, as it did in the 90th Congress, an amendment to include a doctor of optometry in section 1961(r) of title XVIII.

Adoption of S. 1402 would permit the beneficiary to go directly to the physician or optometrist of his choice.

Adoption of S. 1402 would avoid the additional delay and expense created by the present requirement that a physician must certify the "medical need" of a beneficiary to consult an eye care specialist.

Adoption of S. 1402 would not alter the mode of practice of optometrists or physicians; neither would it conflict nor interfere in any way with State laws governing the practice of optometry or medicine.

Utilization of allowable eye care services would not necessarily be increased; rather, those beneficiaries requiring such allowable services would simply be able to obtain them with less difficulty. This, it seems to us, is a reasonable and valid expectation and is in accord with the spirit and intent of the law.

On behalf of the American Optometric Association, I thank you and the committee for your time and attention. Dr. Demmer, Mr. Averill, Mr. Lavanty and I would be happy to respond to any questions you might like to ask.

The CHAIRMAN. Thank you very much, gentlemen.

Dr. McCRARY. Thank you, sir.

The CHAIRMAN. Our next witness will be Mr. Royce P. Noland, executive director, American Physical Therapy Association, accompanied by Clem Eischen, chairman of self-employed section of APTA.

Will you proceed, sir.

STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR, AMERICAN PHYSICAL THERAPY ASSOCIATION; ACCOMPANIED BY CLEM EISCHEN, CHAIRMAN OF SELF-EMPLOYED SECTION, APTA

Mr. NOLAND. Thank you, Mr. Chairman.

My name is Royce P. Noland, and I am the executive director of the American Physical Therapy Association.

As you have identified, Mr. Clem Eischen, chairman of our self-employed section, is here with me today, as a resource witness.

The CHAIRMAN. We will put your entire statement into the record and, perhaps, you can abbreviate it.

Mr. NOLAND. I was going to suggest that it could be entered into the record and I will extract from it just a few pertinent points.

The CHAIRMAN. Yes.

Mr. NOLAND. The American Physical Therapy Association has long advocated the optimum utilization of all physical therapists under the medicare program in accordance with the needs of the program. We are, therefore, most pleased to see this provision which provides

for the services by individual physical therapists in the amendments now in H.R. 17550. Inclusion of the proprietary physical therapist in the program will enhance the availability of services to the beneficiary group, have a positive effect on controlling costs, and make possible the optimum utilization of personnel and facilities within the community and give both the physician and the patient an optimum level of free choice of health personnel to utilize, without sacrificing quality of service or reasonable control of the services.

For these reasons, the American Physical Therapy Association supports this section of the amendments.

We cannot, however, support the $100 limitation imposed for these services. We would urge that these services be made inherent in any plan for utilization review which might be adopted by Congress.

An alternative would be to identify an arbitrary dollar figure, not necessarily $100, perhaps more, perhaps less, and then specify that if additional care is to be reimbursed there must be a reevaluation of the patient's need for physical therapy and an identification of a specific program for continuation. This might occur via recertification by a physician, recertification by a utilization review body or by consent of professional consultants within the offices of the fiscal intermediary.

Guidelines are abundant which would give instant identification to over utilization or under utilization of physical therapy, and could red flag any inappropriate care.

Our association and its various State component chapters are fully equipped to give this kind of guideline information to any intermediary as well as a professional consultation on utilization review.

We are not, therefore, taking the posture of objecting to the $100 ceiling necessarily because it represents too small a figure, but because, as a ceiling, it will not be effective to achieve the intended goal.

In reference to section 1861, the bill section 254, found on page 147 of H.R. 17550, which would establish a salary equivalency for the cost of physical therapy services provided in a provider's setting, our association has recognized that there has been in selected and isolated situations misuse of the program either out of ignorance of intent of the scope for the program or in certain instances, apparent calculated effort to abuse the program.

We deplore misuse regardless of the circumstances or motivation. We recognize that the House Ways and Means Committee sharing our concern over misuse, real or potential and the increasing costs of the program, is seeking a device to bring about reasonableness in the cost for physical therapy services. We are sure that it is the desire, this is the desire, of the Committee on Finance. We concur in the concept of appropriate control mechanisms which would effectively bring about an atmosphere in which only reasonable charges were being made for the service of physical therapy.

It is our contention that the concept of trying to bring about this by arbitrarily fixing the maximum cost that a facility might encounter in arranging for physical therapy services by equating this to a "salary" level, is neither realistic nor will it be effective in bringing about the desired end.

It must be recognized that the larger share of physical therapy services rendered under the auspices of a home health agency or in ex-

tended care facilities are rendered by physical therapists who are participating with the provider of service on a less than full-time basis.

Any reasonable arrangement between the physical therapist and a provider of service must take into account:

1. That the normal pattern is that the person is less than full time.
2. That there is the factor of "portal to portal" time.
3. And that a physical therapist functioning on a less than full-time basis has periphery costs inherent in his activity.

So although we sympathize with the motivation for this amendment, we urge that it be altered and that the point of scrutiny to establish reasonableness of the cost be at the level between the provider and the fiscal intermediary.

We propose that this section of the bill be deleted and the following language substituted. On page 147 of House bill 17550, section 1861 (v), new number 5, delete beginning in line 15, after the word "title" and insert:

> Shall not exceed an amount allowable under a fee schedule to be negotiated within the state, by the state agency, or the reasonable cost of such service as determined by the cost reimbursement formula, whichever is less.

Fixed fee schedules for physical therapy service have much precedent in this country because of the long history of physical therapy being one of the primary services included under third party payer programs, both private and public.

Therefore, the establishment of a reasonable community standard for a fee schedule for physical therapy could be accomplished without undue difficulty and there would be abundant guidelines available to each State agency to accomplish this.

This association cannot support a concept that simply because an institution generates a cost figure it is entitled to that amount of payment without other guidelines and controls.

Therefore, the ceiling of a negotiated fee schedule should also be included. Efficiency should be encouraged, and this proposal would indeed encourage efficiency as well as bring about the needed control mechanisms, which are the objective of this portion of the House bill.

Mr. Chairman, I will comment briefly on the——

Senator ANDERSON. Did you deal with the Bennett amendment?

Mr. NOLAND. That is what I am going to do now. I will comment briefly on the Bennett amendment, the Professional Standards Review Organization concept.

We feel that Senator Bennett should be commended for coming up with this interesting and exciting concept.

We would reiterate the long-standing position of our association in stating that in the presence of a third party payer, there must be effective third party review of the services provided. The comprehensive plan introduced by Senator Bennett far exceeds any previous proposal along the lines to accomplish that end.

I know that concern has been expressed by other professional associations involved in the health care system, and by organizations representing institutions providing health care over the singular identity of the physician as a participant in the plan, and we share this concern.

We recognize, however, the primary role the physician plans in the health care system.

One of the most valuable aspects of this proposal is the localization of the review mechanism. We recognize the local medical society as perhaps being the most logical existing health organization available for this purpose. By its very constituency, however, it obviously would not have within its membership, persons sufficiently knowledgeable or sufficiently objective to undertake the total scope of the review process for all aspects of health care.

We would, therefore, propose the following changes to the Professional Standards and Review Organization concept:

1. Participation of appropriate other health professionals and representatives of health organizations be made mandatory.
2. The State-wide Professional Standards Review Council be expanded in its constituency to include representatives of other health professions and health organizations.
3. The National Professional Standards Review Council be reconstituted so that a majority of the Council be made up of persons selected from other health professions and representatives of health facility organizations as well as public representatives.

We feel that our proposals for change, which could be easily encompassed into the program, would not markedly affect the organizational form of the program or the controls exercised by the Congress, the Department of Health, Education, and Welfare, or the participation, the reasonable participation, of organized medicine.

Mr. Chairman, we appreciate the fine continuing monitoring of this program by this committee and its staff.

We also appreciate the many opportunities that you have given our association to express our views, and we hope that they have been helpful.

(The complete statement follows. Hearing continues on page 629.)

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association represents over 14,000 qualified physical therapists in the United States. This constitutes well over 80 percent of the physical therapists in the country. There are 52 schools of physical therapy accredited by the Council on Medical Education of the American Medical Association, in collaboration with the American Physical Therapy Association. Licensing acts prevail in 49 states to govern qualifications, standards, and scope of practice.

The American Physical Therapy Association has been an active participant in advocating legislation and consulting on regulations for the purpose of advancing the availability of quality health care through comprehensive health care programs.

In a program of health care service such as Medicare, simple allusion to high quality comprehensive health care is insufficient and the promotion of this concept alone represents inadequate participation by any health profession or its representative association.

Neither is it adequate that the administrators of the program should see as the singular goal merely arrange financial details, spend allotments, and reimburse vendors. If optimums are to be reached then there must be a collaboration between government agencies and the health professions so that continuous attention can be given to how the money is used and with what effects.

Every effort should be made to obtain as much effective health care as is possible from the resources that are available. It is to this end that we present the following testimony on H.R. 17550, Social Security Amendments of 1970, including comment on Senator Bennett's proposal for Professional Standards Review Organization.

Services by Individual Physical Therapists

H.R. 17550 (Bill Sec. 254) Section 1861(p) and 1833

The American Physical Therapy Association has long advocated the optimum utilization of all physical therapists under the Medicare program in accordance with the needs of the program. We are, therefore, most pleased to see this provision in the amendments now before the Congress. Inclusion of the propriatary physical therapist in the program will enhance the availability of services to the beneficiary group, have a positive effect on controlling costs, and make possible the optimum utilization of personnel and facilities within the community and give both the physician and the patient an optimum level of free choice of health personnel to utilize, without sacrificing quality of service or reasonable control of the services. For these reasons, the American Physical Therapy Association supports this section of the amendments.

We cannot, however, support the $100 limitation imposed for this specific item. We would recognize the comfort that such a dollar figure ceiling may give an actuary, but we must also view optimum health care. The arbitrary termination of the treatment program in progress because of reaching a fixed dollar figure, does not seem congruous with the rest of the Medicare program. We strongly support, however, control mechanisms which will make not only the cost reasonable but the nature and duration of services appropriate to optimum health care.

We would urge that these services be made inherent in any plan for utilization review which might be adopted by Congress. When Senator Bennett presented his proposal for the Professional Standards Review Organization to Congress, he stated in his remarks to the Senate as follows: "During work on the amendment, it became obvious that the present system of Medicare recertification of need for hospital care makes little sense from a professional standpoint. Currently a physician must recertify as to continuing need for hospitalization at the twelfth hospital day. This was selected arbitrarily, and bears no relationship to whether the patient's age and illness would usually warrant a longer or shorter hospital stay."

We certainly concur in his point and we feel that this very point is applicable to the arbitrary $100 limit. Allowing $100 worth of services for a service that was not necessary in the first place represents abuse of equal potential to services which may have initially been needed and then are continued beyond a reasonable period of time. Thus, $100 will never be a sacred figure. In all cases, the needed amount of care and its dollar value will always be less than or more than or more than the $100. It is our contention that the amount allowable should be exactly what is necessary.

We would further quote Senator Bennett, "With professionally developed data available, it would be far more sensible and efficient for the Professional Standards Review Organizations to apply the average length of stay for a given diagnosis as a checkpoint for review of continued need for hospitalization." This very checkpoint approach could be used for physical therapy services. Guidelines are abundant which would give instant identification to under or over utilization of physical therapy and could "red flag" any inappropriate care. This Association and its various state component chapters are fully equipped to provide this kind of guideline information to any intermediary, as well as professional consultation of utilization review.

We are not taking the posture of objecting to the $100 necessarily because it represents too small a figure, but because as a ceiling, it will not affectively achieve the end, other than to make it actuarially comfortable to predetermine the maximum amount this added service might represent to the program.

I can sympathize with the Social Security Administration's desire to have this kind of predetermined knowledge, but we cannot concur that it represents good health care management or fiscal control. Another alternative to the one previously noted in this testimony would be to identify an arbitrary dollar figure (not necessarily $100—perhaps more, perhaps less) and then specify that if additional care is to be reimbursed there must be a reevaluation of the patient's need for physical therapy and an identification of a specific program for continuation. This might occur via recertification by the physician, recertification by a utilization review body, or by consent of professional consultants within the offices of the fiscal intermediary.

SALARY EQUIVALENCY

H.R. 17550 (Bill Sec. 251) Section 1861, 5—Page 147

Our Association has recognized that there has been in selected and isolated situations, misuse of the program either out of ignorance of intent of the scope for the program or in certain instances, apparent calculated effort to abuse the program. We deplore misuse regardless of the circumstances or motivation. We recognize that the House Ways and Means Committee sharing our concern over misuse, real or potential and the increasing costs of the program, is seeking a device to bring about reasonableness in the cost for physical therapy services. We are sure that is the desire of the Finance Committee. We would concur in the concept of appropriate control mechanisms which would effectively bring about an atmosphere in which only reasonable charges were being made for the service of physical therapy.

It is our contention that the concept of trying to bring this about by arbitrarily fixing the maximum cost that a facility might encounter in arranging for physical therapy services by equating this to a "salary" level, is neither realistic nor will it be effective in bringing about the desired end. It will further cause an administrative headache of profound proportion to the physical therapist, the provider of service, and the Social Security Administration, administrators of the program.

It must be recognized that the larger share of physical therapy services rendered under the auspices of a home health agency or in extended care facilities are rendered by physical therapists who are participating with the provider of service on a less than full-time basis. Many of these physical therapists maintain treatment centers of their own. This implies overhead costs inherent in any type of proffessional practice and absence from their treatment center represents a need to be fiscally productive to the extent to meet costs of operation of their facility, plus a reasonable income for the practitioner. Salary equivalency does not accomplish this.

This would also be true for a physical therapist employed by a hospital, for example, and the hospital was rendering service in an extended care facility. It would not be economically feasible for any hospital to have a staff physical therapist go to an extended care facility, provide care and do this on a basis of "salary equivalency." Any reasonable arrangement between the physical therapist and a provider of service must take into account:

(1) That the normal pattern is that the person is less than full-time,
(2) "Portal to portal" time,
(3) Periphery costs inherent in the physical therapist who is other than the full-time employee of a provider or other health institution.

Although we sympathize with the motivation for this amendment, we urge that it be altered and that the point of scrutiny to establish reasonableness of the cost be at the level between the provider and the fiscal intermediary.

We propose that this section of the bill be deleted and the following language substituted. On page 147 of House Bill 17550, Section 1861 (v), new number 5, delete beginning in line 15, after the word "title" and insert:

"Shall not exceed an amount allowable under a fee schedule to be negotiated within the state, by the state agency, or the reasonable cost of such service as determined by the cost reimbursement formula, whichever is less."

Fixed fee schedules for physical therapy service have much precedent in this country because of the long history of physical therapy being one of the primary services included under third party payer programs, both private and public.

Therefore, the establishment of a reasonable community standard for a fee schedule for physical therapy could be accomplished without undue difficulty and there would be abundant guidelines available to each state agency basing the determination on existing schedules of fees now existing within the state for other third party payer programs such as industrial accident commissions, cripple children services, Medicaid, and private liability insurance programs.

It should be further clarified that this proposal is not an extension of the concept of "reasonable charges" now in vogue among physicians. This would be a negotiated schedule of fees which would be clear and explicit in its inclusion and amounts. This proposed change in the section of H.R. 17550 also provides another ceiling limitation, that being the reasonable reimburseable cost and that the determination be on whichever of the two methods represents the lesser cost to the program.

If the provider of service can, in fact, perform the service adequately at a figure less than the negotiated fee schedule, then by all means this should be the figure to be used. This Association cannot support a concept that simply because an institution generates a cost figure it is entitled to that amount of payment without other guidelines and controls. Therefore, the ceiling of the negotiated fee schedule should also be included. Efficiency should be encouraged, and this proposal would indeed encourage efficiency as well as bring about the needed control mechanism which is the objective of the House Bill.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Congressional Record August 20, 1970—S13853—Amendment 851

The Professional Standards Review Organization concept in Senator Bennett's amendment presents a most interesting and exciting concept to bring about a rational peer review system. Senator Bennett should be commended for this highly imaginative, constructive, and potentially effective review system.

We would reiterate the longstanding position of the American Physical Therapy Association in stating that in the presence of a third party payer there must be effective third party review of the services provided. The comprehensive plan introduced by Senator Bennett far exceeds any previous proposal along these lines to accomplish that end.

Concern has been expressed by other professional associations involved in the health care system and by organizations representing institutions providing health care over the singular identity of the physician as a participant in the plan. We share this concern. We recognize, however, the primary role the physician plays in the health care system. We also recognize that physician care represents far *less* than a majority of the cost of health care in this country and it does seem in order that the structure of the Professional Sandards Review Organization and the requirements for operation of such an organization include mandatory requirements for effective participation by other health professionals and representatives of health institutions. This can be accomplished without significantly altering the basic structure as proposed in Senator Bennett's amendment.

One of the most valuable aspects of this proposal is the localization of the review mechanism. We recognize the local medical society as perhaps being the most logical existing health organization available for this purpose. By its very constituency, however, it obviously would not have within its membership, persons sufficiently knowledgeable or sufficiently objective to undertake the total scope of the review process for all aspects of health care.

We would, therefore, propose the following changes to the Professional Standards and Review Organization concept:

1. Participation of appropriate other health professionals and representatives of health organizations be made *mandatory*.
2. The state-wide Professional Standards Review Council be expanded in its constituency to include representatives of other health professions and health organizations.
3. The National Professional Standards Review Council be reconstituted so that a *majority* of the Council be made up of persons selected from other health professions and representatives of health facility organizations as well as public representatives.

Since the state and national Professional Standards Review Councils have a primary function of evaluation it is in order that this evaluation be made by a combination of physicians and others involved in the health care system. These recommendations should not be interpreted to imply that physicians are not cognizant of or sensitive to the other health services being provided in this country.

It is unrealistic, however, to assume that they will have sufficient expertise to adequately evaluate the other health services or the health facilities. It is further unrealistic to demand that they gain this expertise, particularly since this expertise already exists in the embodiment of other health professions.

These suggestions should not be interpreted as opposition to the general concept of the Professional Standards Review Organization. On the contrary, we would reiterate our enthusiastic support for this most meaningful and potentially effective means of bringing about effective peer review in this Nation. We feel that our proposals for change, which could be easily encompassed into the program,

would not markedly affect the organizational form for the program or the controls exercised by the Congress and the Department of Health, Education, and Welfare, or the reasonable participation of organized medicine.

The CHAIRMAN. Thank you very much, sir.

The next witness will be Dr. E. Dalton McGlamry, first vice president of American Podiatry Association. He is accompanied by Dr. Nyman and Mr. John R. Carson.

Will you proceed, sir.

STATEMENT OF DR. E. DALTON McGLAMRY, FIRST VICE PRESIDENT, AMERICAN PODIATRY ASSOCIATION; ACCOMPANIED BY DR. S. P. NYMAN, EXECUTIVE DIRECTOR; AND JOHN R. CARSON, DIRECTOR, GOVERNMENT AFFAIRS

Dr. McGLAMRY. Mr. Chairman, I am Dr. E. Dalton McGlamry, first vice president of the American Podiatry Association, and a practicing podiatrist in Atlanta, Ga.

In the interests of conserving the time of the committee, we have submitted a written statement which we would appreciate having in the record.

The CHAIRMAN. We will print the entire statement.

Dr. McGLAMRY. I would like to simply summarize from this only a couple of points that are of major concern to our association, and which have had prominent mention in the committee's hearings today.

One is in the area of peer review, and the other specifically is in the area of Senator Bennett's amendment.

The American Podiatry Association heartily endorses the concept of peer review. We have been engaged in this since 1960, to a very large extent with public and private insurance carriers in this country, and we have had the experience that tells us that where this relationship is present and where peer review is utilized as a preventive mechanism rather than as a court of last resort, that it works. It protects the carrier, it protects the profession, it protects the public.

It can keep costs down, and where there are abuses it can provide for expedient administration of remedies, but where peer review is viewed as something only as a court of last resort, it does not work. Instead the problem is inflated, and abuses are encouraged and do increase when peer review is not effectively utilized as a continuing regular mechanism.

The absence of any Federal guidelines in the health programs with regard to peer review has retarded, we feel, the effectiveness of peer review, and we urge that HEW, in cooperation with concerned health professions, immediately move to draft regulations, specific regulations, for peer review and implement them as a preventive measure rather than as a court of last resort.

We are also aware that there have been abuses by members of our profession, both of medicare and medicaid programs, and we would not like to skirt this.

Where these problems have occurred, and where the local podiatry societies have been involved in peer review, we have been quick to administer remedial medicine. But we cannot effectively administer remedial medicine if we are only brought in after the carrier has a

stack of abuses that should not have been allowed to occur in the first place.

We submit, that it is not that peer review does not work. It is just that is has not been implemented.

With regard to the second point, the Professional Standards Review Organization, the amendment filed by Senator Bennett to H.R. 17550. This amendment would establish at the local level a Professional Standards Review Organization to improve the coordination and conduct of professional review mechanisms.

Although the American Podiatry Association supports the concept embodied in the amendment, we are deeply concerned about specific features of the amendment as it is presently drafted. Each local PSRO would have the responsibility for reviewing all services for which payment may be made under the Social Security Act.

In discharging this responsibility the review organization would be expected to call on the expertise in all areas in which services are rendered. But we feel that professional review of podiatry services can only be efficiently and meaningfully performed where podiatrists are also involved in the review mechanism.

If I could digress for one moment, we have seen States in which peer review was utilized by podiatrists working closely with the carrier in the medicare program and men who might be tempted to abuse programs are aware that their claims are being seen, continuing review of their services is assured. In these areas abuses have been very infrequent indeed, and where they have occurred, they have been appropriately dealt with.

We have other areas in which peer review has not been utilized except as a court of last resort. The medical directors for the carriers in many instances have not felt the need for involvement of the podiatrists as a continuing and constant source of reviewing podiatric services, in these instances we have only heard from the carrier after the abuses were sufficiently out of hand that they were difficult to deal with.

Section 1152(b) of the proposed amendment refers to qualified professional standards review organizations, as it is presently written, as being primarily composed of physicians engaged in the practice of medicine and surgery, we believe if this organization is to be the meaningful mechanism for reviewing podiatric services, the amendment should be broadened and strengthened to assure the full participation of other health care practitioners, including podiatrists in the PSRO activities.

Such a change, we feel, should include a clear definition of "physician", employing for this purpose the precedent established in title XVIII, of the Social Security Act.

Mr. Chairman and members of the committee, we appreciate the opportunity of appearing before you today, and we will be happy to answer any questions that the committee might care to direct to us.

(The prepared statement follows. Hearing continues on page 635.)

STATEMENT OF THE AMERICAN PODIATRY ASSOCIATION PRESENTED BY E. DALTON McGLAMRY, D.P.M., 1ST VICE-PRESIDENT

Re: Position statement on H.R. 17550, including additional recommendations to improve the administration and delivery of podiatrists' services under Medicare and Medicaid.

SUMMARY

With respect to Medicare-Medicaid in general, H.R. 17550 in particular, the following recommendations are advanced to improve the planning for and delivery of foot health services under Titles XVIII and XIX:

Reinstating in H.R. 17550 the requirement that states accomplish by 1977 comprehensive Medicaid programs.

Providing a podiatrist-consultant to the Social Security Administration and assuring podiatrist representation on both the Health Insurance Benefits Advisory Council and the Medical Assistance Advisory Council.

Improving the effectiveness of the Professional Standards Review Organization concept by assuring the involvement and full participation therein of the various health care practitioners participating in federal health insurance and assistance programs.

Amending Section 1862 of the Social Security Act to provide for complete medical and surgical care of the foot, as is the case for other parts of the body.

Amending Section 1861(b)(4) of the Social Security Act to identify the Association's Council on Podiatry Education as the national accrediting agency for podiatric education programs.

Amending Title XIX of the Social Security Act for the purpose of providing a definition of physician which would include the podiatrist.

INTRODUCTION

Mr. Chairman and Members of the Committee: I am Dr. E. Dalton McGlamry, First Vice-President of the American Podiatry Association and a practicing podiatrist in Atlanta, Georgia. The American Podiatry Association, whose membership I represent here today, is a voluntary, non-profit organization, established in 1912 and composed of fifty-three (53) component societies—one in each state, the District of Columbia, Puerto Rico, and a society for podiatrists in Federal Service.

The Social Security Amendments of 1965 and 1967 represented a significant beginning by the Federal government to improve for the nation's aged and disadvantaged citizens the accessibility of needed health services; and though health services available and delivered to these individuals have increased during the last four years, questions of program efficiency and quality remain as overriding national concerns.

The American Podiatry Association supported, and continues to support, the principles embodied in Medicare and Medicaid; but the Association equally recognizes and endorses the necessity for revisions in the law to hasten the attainment of an essential national goal—comprehensive health services for all citizens regardless of economic status.

In recognition of this necessary and challenging assignment, the American Podiatry Association commends the Committee for its recent report, medicare and medicaid, problems, issues, and alternatives. With few exceptions, the report's recommendations provide extensive and constructive guidance for remedying many shortcomings of both Titles XVIII and XIX. And it is to the further credit of the Committee that H.R. 17550, which particularly concerns us today, embodies many of the same recommendations included in the Committee's staff report.

The American Podiatry Association is cognizant of the many current program weaknesses which H.R. 17550 proposes to correct. But recognizing the Committee's desire to conserve time and avoid repetitious testimony, I will restrict my remarks today to those program areas which require remedial action if quality foot health services are to continue to be efficiently delivered to the beneficiaries of both Medicare and Medicaid.

First, however, we would urge the Committee to consider and remedy one major flaw in H.R. 17550, a bill which we generally support as both responsible and constructive. I specifically reference the bill's repeal of the Medicaid provision requiring states to have comprehensive Medicaid programs by 1977. In our opinion, this provision should be retained as a meaningful goal towards which society should strive to achieve, whether the mechanism be Medicaid as we currently understand it, or an improved substitute. The American Podiatry Association supports, as we know individual members of this committee support, the desirability of this goal. That it may require periodic postponement is one thing; to eliminate it entirely is at best regressive and repugnant to millions of Americans who deserve and require its benefits. Not only do we encourage the retention of this essential aim, we urge that every effort be extended to attain it prior to the conclusion of this decade.

ADMINISTRATIVE POLICY RECOMMENDATIONS

On the specific subject of podiatrists' services, the American Podiatry Association has devoted considerable time and effort to assure the meaningful participation of podiatrists in Titles XVIII and XIX. Countless meetings with our membership, carriers, and appropriate federal officials have been held to interpret and clarify regulations, to resolve misunderstandings, and to seek counsel on specific problem areas. These productive experiences convincingly underscore the vital importance of close cooperation between the public and private sectors as both strive to accomplish common objectives. With respect to podiatrists' services, however, this relationship could be additionally strengthened if * * *.

The Social Security Administration would employ on a regular basis the services of consultant podiatrists; and

Both the Health Insurance Benefits Advisory Council and the Medical Assistance Advisory Council had podiatrist representatives.

We are pleased that these administrative recommendations have attracted increased interest at HEW as evidenced by the Medical Services Administration's recent appointment of a podiatrist-consultant to advise MSA on the planning for and delivery of podiatric services under Medicaid. We are confident that such a policy, if implemented in other federal health programs where podiatrists' services are an important part, could immeasurably strengthen both the quality and efficiency of important health services under public supported health insurance and assistance programs. We are therefore hopeful that our specific recommendations earlier advanced can be swiftly accomplished to achieve this objective.

PEER REVIEW

We heartily endorse the Committee's recommendation to make peer review a more effective instrument for evaluating the quality and efficiency of health care. Since 1960, the American Podiatry Association has formally engaged in peer review activities in cooperation with carriers representing public and private insurance programs. Our objective has been and always will be to assure the highest quality podiatric care at the most reasonable cost for all citizens.

In pursuit of this objective, our experiences during the past ten years have clearly revealed that, where peer review committees and carriers work hand in hand, quality and efficiency result, the interests of the public are fully protected, problems are more readily detected, and remedial measures, when required, are more effectively applied.

Conversely, however, where such a spirit of cooperation does not prevail, where peer review is lacking or is viewed only as a "court of last resort" and not as a bonafide preventive mechanism, the potential for abuse, indeed abuse itself, sharply increases. Though quality care is the primary and moral responsibility of the concerned health professions, cooperation among all concerned parties—patients, carriers, and providers of health care—is the most essential requisite for any successful peer review program. In this regard, the absence of any federal guidelines with respect to peer review activities under public supported health programs has retarded the effectiveness of peer review. This problem must be overcome. And we urge HEW—in cooperation with the concerned health professions—to develop and implement meaningful guidelines to improve the effectiveness of peer review.

We are aware that there have been abuses of both the Medicare and Medicaid programs. And where the evidence has justified, our component societies have taken prompt and effective action in response to these circumstances. We fully support, therefore, H.R. 17550's recommendations to prevent and control program abuses. And we want to cooperate in every way to assure the effective application of these recommendations.

For example, the "Medicare Watchdog System" in New York City, about which the Committee has already received testimony, is indicative of the progress which can be achieved when all parties work closely together to accomplish mutual goals. We are particularly pleased with the role our New York College and State society are playing in this program. To eventually realize this type of cooperation in all jurisdictions is our goal.

I must reference once again, however, that where close working relationships have existed between peer review committees and carriers, both public and private, problems have been minimal and often times non-existent. Thus whatever can be meaningfully done to strengthen peer review by promoting closer cooperation between the public and private sectors has our unequivocal support.

PROFESSIONAL STANDARD REVIEW ORGANIZATIONS (PSRO)

A partial solution to this problem was recently filed with the Committee in the form of an amendment to H.R. 17550. Authored by Senator Bennett, this amendment would establish at the local level Professional Standard Review Organizations (PSRO) to improve the coordination and conduct of professional review mechanisms. And though the American Podiatry Association supports the concept embodied in the amendment, we are nonetheless deeply concerned with specific features of the bill as presently drafted.

In its stated purpose, each local PSRO would have the responsibility for reviewing all services for which payments may be made under the Social Security Act. In discharging this responsibility, the PSRO is called upon to determine the medical necessity of the services involved and to judge their conformity to "professionally recognized standards of health care."

The amendment further stipulates that, in making PSRO designations at the local level, the Secretary of HEW must give first priority to local medical societies or subsidiary organizations which represent a substantial portion of physicians in respective geographic areas. Only when such groups are either unwilling or unable to accept such PSRO responsibility would the Secretary make such agreements with other private nonprofit, or public agencies with similar professional competence. Yet the role of other health care practitioners, including podiatrists, in this review process has either been overlooked or totally obscured in the amendment. And we strongly object to this aspect of the amendment.

The 1967 Medicare amendments to the Social Security Act expressly provided for the inclusion of the podiatrist within the definition of the term "physician." This legislative act gave recognition to the fact that the doctor of podiatry, as well as the doctor of medicine, doctor of osteopathy and doctor of dentistry, has the independent right to diagnose and treat by medical, surgical and other means, subject, of course, to the applicable state law. Accordingly, it follows that the medical necessity for the services performed by these practitioners is primarily a matter of their own professional judgment.

We fully support this concept as one significant way to assure the efficient and qualitative delivery of health services, regardless of the means of payment for these same services. But such review procedures can and should only be made by the practitioner's own colleagues, employing the well-established methods of peer review.

Section 1152(b) of the proposed amendment refers to qualified professional standards review organizations as being primarily composed "of physicians engaged in the practice of medicine or surgery." Yet, the same section mandates that the organization have "available professional competence to review health care services of all types and kinds." It is apparent that to be effective and meaningful in the case of podiatric services, this task must be performed by members of that profession.

While the use of the term "physician" in the proposed Section 1152(b), when read together with the summary, appears to exclude podiatrists, the word "physician" occurs elsewhere in the amendment without additional explanation. To further complicate the matter, a new term, "health care practitioner," is introduced for which no definition at all is provided.

As we have earlier stated, the American Podiatry Association has long been active in the peer review facets of health insurance programs. We believe that our members' experience will make a significant contribution to the effective application of review standards to services authorized under the Social Security Act. However, to most effectively discharge this responsibility, the amendment as presently written must be strengthened to assure the involvement and full participation of other health care practitioners, including podiatrists, in PSRO activities. Such a change must include, though not necessarily limited to, a clear definition of "physician" in the amendment, employing for this purpose the precedent established in Title XVIII of the Social Security Act.

LEGISLATIVE RECOMMENDATIONS—MEDICARE

In addition to the aforementioned recommendations, there are additional legislative proposals which, if enacted, would decisively improve the delivery of foot health services under Medicare and Medicaid.

Following the enactment of P.L. 90-248, which added podiatrists' services to the physician benefits of Medicare (Title XVIII, Part B), the elderly were

afforded important program benefits. Experiences to date, however, have exposed certain inadequacies with respect to the administration and provision of foot health services under Medicare; and to continually assure quality foot health services for the elderly, it is essential that these problem areas be remedied.

Section 1862 of the Social Security Act lists the services excluded from coverage under the Medicare Program. However, podiatrists' experiences have clearly demonstrated that present exclusions neither control costs nor assure that only necessary foot care is furnished. Instead of considering the treatment of the foot on the same basis as other parts of the body, Section 1862 (paragraph 13) employs language which even three years after enactment defies clear interpretation. As a result, the Social Security Administration is still seeking the correct application of this paragraph to specific problem areas, and we are still awaiting decisions on several important questions of interpretation. It is our recommendation that the Medicare Program, like other health insurance plans, provide for complete medical and surgical care of the foot, as is the case for other parts of the body.

Secondly, a conforming amendment to Title XVIII, Section 1861(b)(4), is required to bring podiatric inpatient hospital services in line with other physicians' services. This section enables a hospital under Part A to be reimbursed for the reasonable costs of the services of interns and residents in an approved teaching program. However, Section 1861, which identified the various accrediting agencies that approve such programs, inadvertently omits the Council on Podiatry Education of the American Podiatry Association. This oversight should now be corrected. The Association's Council on Podiatry Education, recognized by the U.S. Office of Education and the National Commission on Accrediting as the national accrediting agency for podiatric education programs, should be specifically included in Section 1861(b)(4) of the Act.

LEGISLATIVE RECOMMENDATION—MEDICAID

Podiatrists now participate in thirty-four of the fifty-two approved state Title XIX programs. And our experiences have clearly demonstrated a lack of consistency between the Medicare and Medicaid programs. I refer specifically to the lack of uniformity in the Act's definition and interpretation of the term "physician."

Section 1861 (r) of the Act includes the podiatrist under the term "physician" for the purposes of Title XVIII. Title XIX, on the other hand, does not define the term "physician." Instead the meaning of the term has been left to administrative interpretation. The result has been to exclude the services of podiatrists from the meaning of "physician services" for purposes of Title XIX. This particular lack of consistency has produced serious consequences for carriers, administrators, and—most importantly—the program's beneficiaries.

A specific example of this problem is the Medicare "buy-in" arrangement, in which more than forty states participate. These states, by paying the Medicare Part B charges, qualify the elderly poor for Medicare benefits, including podiatrists' services which are defined as physicians' services under Title XVIII. Yet in many of these same states, Medicaid beneficiaries under 65 are denied a podiatrist's services.

It is recommended that this inconsistent application of the law be remedied by amending Title XIX for the purpose of defining the term "physician" to include the podiatrist.

SUMMARY

In conclusion, Mr. Chairman, I fully appreciate the massive but essential task which which your committee is charged. And as each of us realizes, the achievement of a national health policy, one which assures every American equal access to quality health care, will not be easily or quickly accomplished. Yet it is imperative that the nation responsibly build on an already impressive record by immediately responding to Medicare and Medicaid's inadequacies, which—as far as podiatrists are specifically concerned—must summarily include:

Reinstating in H.R. 17550 the requirement that states accomplish by 1977 comprehensive Medicaid programs.

Providing a podiatrist-consultant to the Social Security Administration and assuring podiatrist representation on both the Health Insurance Benefits Advisory Council and the Medical Assistance Advisory Council.

Improving the effectiveness of the Professional Standards Review Organization concept by assuring the involvement and full participation therein of the

various health care practitioners participating in federal health insurance and assistance programs.

Amending Section 1862 of the Social Security Act to provide for complete medical and surgical care of the foot, as is the case for other parts of the body.

Amending Section 1861 (b) (4) of the Social Security Act to identify the Association's Council on Podiatry Education as the national accrediting agency for podiatric education programs.

Amending Title XIX of the Social Security Act for the purpose of providing a definition of physician which would include the podiatrist.

Mr. Chairman, thank you for your courtesy in inviting us to present this testimony. We look forward to cooperating with you, with this Committee and the Congress in providing improved health care for all Americans.

The CHAIRMAN. Any questions, gentlemen?

Senator MILLER. I just want to clarify your position on this Bennett amendment.

What you are suggesting, I think, is that you are concerned about the peer review mechanism if you have an organization which does not reflect the profession concerned.

Now, suppose we have peer review organizations which had two or three medical doctors on them, and had an optometrist, but no podiatrist, you would not have confidence in that organization because podiatry is not represented on the council; is that so?

Dr. McGLAMRY. Senator, our experience has shown that medical doctors reviewing podiatry claims have not been adequate to pick up abuses at the earliest inception. We feel that a competent podiatrist, seeing these claims as a part of the committee, as a part of the review organization, is able to spot these things in their earliest form, and we believe also that other podiatrists, knowing that the representatives of their profession are members of this review organization, will have respect for the review committee and will know that abuses will be spotted early.

Senator MILLER. Well, then, your answer to my question is that you would not have confidence.

Dr. McGLAMRY. I think that is accurate.

Senator MILLER. All right. I share your view. I just want it for the record.

Now, will it be feasible to have the various health organizations have, let us say, suborganizations within the overall organization so that if you have a podiatry claim then you will have that referred to the organization, and the organization, in turn, while it sits over the whole operation and might serve as a final court of arbitration, so to speak, for this work it would have suborganizations within itself which deal with the various professions. Would that be a feasible approach?

Dr. McGLAMRY. Yes, sir; we think this is extremely feasible.

Senator MILLER. Well, what I am suggesting here is that you might have this overall organization which might sit as the final arbiter in some tough cases, but for most of its operations you would have suborganizations so that podiatry claims would be considered only by a podiatrist, maybe two or three podiatrists; a medical claim by medical doctors, and so on.

Would this be a feasible alternative instead of setting up one sole organization that may have two or three medical doctors and optometrists and a podiatrist?

Dr. McGLAMRY. We think that is a feasible approach, providing there are lines of communication open in vertical as well as horizontal directions with the people involved in this.

Senator MILLER. What I would foresee there as a possibility would be that you would have, say you had one from each of the professions on the council itself, but when it came to the general operations you might have three or four podiatrists, you might have three or four medical doctors, three or four optometrists, say, probably on the suborganization one of whom would be a member from the top organization, so that you would have that communication and liaison.

But we are working in an area that is experimental, so to speak, and I am just wondering what your idea on that would be.

Dr. McGLAMRY. This is a real sound approach, and we have offered to this committee assistance in this area and we have offered to help the Social Security Administration draft such standards and to volunteer personnel to assist in this area.

We think that the type of mechanism such as you described that involves the various groups in the review process is bound to make for more respect for the program and to help cut costs.

Senator MILLER. Now, one other question on the Bennett amendment relating to the organization. The amendment provides for Federal Government payments to the organization. Here you talk about volunteer services.

Do you think it is necessary or desirable that this be on a payment basis, or do you think it is feasible to have this on a voluntary basis by the professions concerned?

Dr. McGLAMRY. I am glad you asked me that because if I volunteered it I might have gotten shot, but since you asked me, I have witnessed over the last 10 years in peer review, up until medicare, many members in all professions volunteering, accepting responsibilities of peer review, with never a thought of being compensated for the services other than the satisfaction of knowing that things are being protected, with the exception of the persons who were involved to the extent of half-time, full-time, or where it really encroaches on their professional practice activities.

But since the advent of medicare, there has been a tendency to pay for every single thing that is being done, and I think that the members of our profession, while they would not want to be singled out as the only ones working for nothing, they would be perfectly happy in every instance to volunteer service without cost and without remuneration for time lost from office in order to see it meaningfully implemented.

Senator MILLER. Thank you very much.

The CHAIRMAN. Thank you, gentlemen.

Dr. McGLAMRY. Thank you.

The CHAIRMAN. Now, the next witness will be Mrs. Harriet Tiebel, executive director of the American Occupational Therapy Association.

STATEMENT OF HARRIET TIEBEL, EXECUTIVE DIRECTOR, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION; ACCOMPANIED BY RUSSELL DEAN, WASHINGTON REPRESENTATIVE

Mrs. TIEBEL. Thank you, Mr. Chairman, for the privilege of being here.

I am Harriet Tiebel, executive director of the American Occupational Therapy Association. With me is Mr. Russell Dean, our Washington representative.

My statement is a short one.

Representing the membership of the American Occupational Therapy Association, we appreciate the opportunity given us to present this statement in support of requests to include additional occupational therapy services in amendments under consideration to social security laws, title XVIII of Public Law 89-97, parts A and B.

The committee may not be familiar with the nature and functions of the occupational therapy profession as various changes in the medicare law have been under consideration. Occupational therapy is one of the older health professions. The American Occupational Therapy Association, incorporated in 1917, now has 10,954 registered occupational therapist and certified occupational therapy assistant members serving in hospitals, clinics, extended care facilities, nursing homes, home care programs, schools, universities, and a growing number in private practice.

The occupational therapist becomes eligible for registration by completing a baccalaureate or masters degree in a university having a curriculum accredited by the council on medical education of the American Medical Association in collaboration with the American Occupational Therapy Association. Registration is by a national examination given twice each year by the American Occupation Therapy Association. The occupational therapy assistant is eligible for certification when he completes a course approved by the American Occupational Therapy Association.

Occupational therapy is the art and science of directing man's engagement in selected activities in such a way as to promote and maintain his health, diminish dysfunction and pathology, and enhance the capacity to adapt and to function with increasing satisfaction to self and others.

The occupational therapist is concerned with the effects of activity upon the whole person, how the individual responds to the environment in life tasks and adapts his behavior in social relationships and all the meaningful activity he undertakes.

Occupational therapy services are provided by qualified registered occupational therapists and certified occupational assistants through provisions of the medicare legislation enacted in 1965 and amended in 1967.

Under title XVIII of Public Law 89-97, part A, occupational therapy may be provided when ordered by a physician in hospitals, extended care facilities and with certain limitations in home health agencies.

Reimbursement is made through the provider facility.

In the case of medicare patients, adjustment to the home environment and independence of function in the home are primary occupational therapy goals.

The independent functioning of the older person in the home can make the difference between family members continuing to care for that person or becoming a part of the labor force outside the home.

The Report to the Congress on Independent Practitioners under Medicare, dated December 28, 1968, submitted by the Secretary of Health, Education, and Welfare, recommended (p. 55) that:

> Coverage be expanded for services of occupational theripists . . . that meet requirements established by the Secretary and designed to promote maximum coordination, continuity and quality of care. . . .

In recent months an increasing volume of complaints has reached the American Occupational Therapy Association, not only from occupational therapists but from other health professionals and agency administrators about the disruption of services to patients when they cannot be legally provided by outpatient departments or in home health agencies.

Omissions in the law are responsible for the confusion and the cutting off of services ordered by physicians.

Appropriate health services to the public are in jeopardy unless the basic law is changed in two areas.

Our requests for changes in medicare amendments to the social security laws are addressed to these two omissions:

No. 1. Section 1814(a)(2)(D), section 1835(a)(2)(A), and section 1861(m). Section 1814 provides that, as a condition of payment for home health services, a physician must certify that the patient needed home health services in the form of skilled nursing care or physical therapy or speech therapy. Need for, and provision of, one or more of these services is a prerequisite for paying for any other service, such as occupational therapy.

This is a critical error in the law, interfering with local professional judgment in providing health care to medicare patients. The physician should be free to choose whatever recognized form of treatment he feels will meet the patients' needs most effectively.

Interposing artificial requirements that certain treatment forms must first be instituted before the desired and needed type may be provided interferes with patient care and leads to higher costs rather than savings. In many cases occupational therapy logically comes later in the individual's treatment, translating skills relearned into functional ability.

In practice many patients are undergoing an occupational therapy regimen at the time they are discharged from the hospital or extended care facility and returned to their homes for completion of the treatment program there. Under present law, one of three things must happen:

The patient must be retained in the hospital, at additional cost, until the treatment is completed; or

He must be sent home and the needed treatment halted; or

Some subterfuge must be found, such as instituting one of the presently required three types of service even if not needed, in order to complete the treatment at home.

Section 254 of H.R. 17550 would further compound and reinforce these problems by making certain amendments to section 1861(p) and to section 1833 of the Act.

Section 1835(a)(2)(A) repeats the above requirement for the purpose of payment of claims and section 1861(m) sets forth the services, including occupational therapy, which may be provided in home health services, subject to the above requirements.

No. 2. A different problem arises out of the provisions of section 1861(p) and section 1861(a)(2)(D), dealing with outpatient physical therapy services.

When the act was amended in January 1968 (Public Law 90-2 248), provision was made for outpatient physical therapy services, a laudable step.

The failure to make similar provision for occupational therapy services has done a distinct disservice to the continuity of patient care in institutions and facilities throughout the country. We believe this was an inadvertent omission. In much the same manner that home health services have been arbitrarily constrained and often abruptly terminated, this deficiency in the authorization for occupational therapy outpatient services not only interferes with good patient care but encourages the retention of patients in hospital facilities in order to complete treatment and thus contributes to unnecessary costs.

RECOMMENDATIONS

We respectfully urge the committee to include amendments to resolve the two problems, specifically:

That sections 1814 and 1835 of the act be amended to authorize the provision of, and payment for, occupational therapy services in home health programs, whether provided as a single patient-care service or in combination with other professional health care services.

That section 1861 be amended to authorize the provision of, and payment for, occupational therapy outpatient services.

ADDITIONAL RECOMMENDATION

The American Occupational Therapy Association also recommends that when a change in basic philosophy of title XIX of the law is considered, attention be given to specific provision of consultative services by occupational therapists to nursing home facilities. By such intervention occupational therapy services can be extended beyond individual treatment by assisting the nursing home staff in understanding rehabilitation concepts and the value of appropriate activity for all patients by maintaining continued support and supervision of the assistants and aides in occupational therapy skills.

The CHAIRMAN. Thank you very much for your statement. Any questions, gentlemen?

Senator WILLIAMS. No questions.

The CHAIRMAN. Thank you very much.

Mrs. TIEBEL. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness will be Mr. Ralph Haskins, member of the Board, American Medical Technologists; accompanied by Mr. Worth Yoder, general counsel.

Will you proceed, sir?

STATEMENT OF RALPH S. HASKINS, NATIONAL BOARD MEMBER, AMERICAN MEDICAL TECHNOLOGISTS; ACCOMPANIED BY WORTH YODER, GENERAL COUNSEL

Mr. HASKINS. Mr. Chairman and members of the committee, my name is Ralph Haskins, of Little Rock, Ark. I am a past president of the American Medical Technologists, and am currently a member of the board of directors.

I am accompanied by Mr. Worth Yoder, general counsel of AMT, and we have submitted a written statement which we request be included in the record of the Senate committee hearings.

I wish, in the interests of your time, to present an overview relative to the problems.

The CHAIRMAN. We will print your entire statement. I hope you can summarize it. Hit the high points of it for us.

Mr. HASKINS. Thank you, Mr. Chairman.

AMT is a National Registry of Medical Technologists founded in 1939 and headquartered at 710 Higgins Road, Park Ridge, Ill.

Many of our registrants work in medical laboratories, physicians' offices, and in research departments in the independent laboratories. AMT is the largest independent registry for medical laboratory personnel.

Beginning in 1962, AMT initiated a complete new study of the educational requirements for the training of medical technicians and technologists. Our goals then and now are to present meaningful, valid, and honest credentials of our registrants to prospective employers. We found it was not possible to fulfill our objectives of valid credentials without upgrading minimum standards of students who, after graduation, would apply for registration.

Our standards committee obtained every training program that we could find, and outlined the minimum training programs that we believed necessary to adequately train a medical technician. This minimum outline was sent to schools of medical technology, pathologists, educators, hospital laboratory directors, junior colleges, and just about anyone interested in the training of laboratory personnel.

We asked them to review the standards and send us their comments. The minimum outline was used. Following this, suggestions were submitted and many of the problems relative to training were brought into focus, tuition, library facilities, physical plant, equipment, interest qualifications, instructor qualifications, instructor-student ratio, length and content of courses, et cetera.

Who would evaluate these programs? Who would determine whether the graduate could fulfill the duties expected on the jobsite? Is the product of the training objective well trained?

The board of directors decided to set up an accrediting bureau composed of pathologists, educators, scientists, hospital administrators, school owners, physicians, medical technologists, and medical technicians.

This accrediting bureau was unique in that AMT members were a minority on the board of directors. This program was funded by the AMT without Government or other outside financial aid.

The accrediting bureau is a completely autonomous group. The bureau manual has been revised many times. However, in its present form it contains all necessary guidelines for a 2-year training program in a vocational school or junior college as a medical technician.

The U.S. Office of Education has recognized the accrediting bureau, and the accrediting bureau of medical laboratory schools has been added to the list of nationally recognized accrediting associations and agencies.

AMT is excluded from recognition by the AMA although they have talked to us about taking us into their umbrella.

The tragic part of this tale is the fact that AMT and graduates of these accredited programs are excluded from the medicare regulations. We have been informed that recognition will be printed in the

manual used by the official inspectors but not in the manual of the conditions when they are revised.

To those of you who are knowledgeable about these medicare regulations, it is even more tragic that the clinic laboratory assistant program (CLA) sponsored by the American Society of Clinical Pathologists as an aide program has been designated as at the level of technician by the authors of the medicare regulations.

The quality training program of the AMT is not mentioned even though it is a training program requiring 2 years of intensive study compared to the 1 year apprentice-type program of the CLA.

AMT exclusion from the medicare regulations brings about an even greater question when one inspects the reports of two northeastern university surveys financed by the Government regarding the duties of medical technologists and technicians in which Professors Goldstein and Horowitz found that 95 percent of the duties performed were essentially the same.

Professor Ammer of the same institution found essentially the same thing in another investigation. These investigations were funded by HEW but were ignored by the authors of the medicare regulations.

It is not my purpose to condemn the ASCP or the CLA program or any other group interested in contributing to the paramedical team. It is our belief that before hundreds of thousands of dollars are spent in training more people or trying to retrain people who have left the profession, it would appear to have more merit to give recognition to the graduates of quality training programs that are entirely capable of performing the duties in the medical laboratory, but who are excluded by the medicare regulations.

We have made numerous trips to HEW trying to resolve this problem.

We have submitted many letters from pathologists and hospital laboratory directors recommending the graduates of these programs. To date, the success of our efforts in seeking changes is hardly measureable.

We have followed the suggestions given by HEW for several years, to no avail.

The single best solution is to seek administrative changes in the medicare regulations to resolve the exclusion of qualified taxpaying laboratory personnel from their right to work in a field for which they have been trained at the level of their ability, and these changes should include an upward progression program.

As my prepared statement indicates at page 7, this committee directed HEW to review the arbitrary paper requirements which disqualify really qualified personnel from the program. To my knowledge HEW has not made these revisions.

I wholeheartedly subscribe to the approach of administrative changes and will continue to assist in any way to resolve the problem of exclusion of qualified persons from working in the laboratories under the medicare program.

I wish to express my gratitude for this opportunity to present these facts to the committee, and on behalf of the AMT members of each State of the Union, I would also like to express their thanks for allowing me to testify in their behalf.

(The prepared statement follows. Hearing continues on page 647.)

STATEMENT OF RALPH S. HASKINS, NATIONAL BOARD MEMBER, AMERICAN MEDICAL TECHNOLOGISTS

Mr. Chairman—members of the Committee. I am Ralph S. Haskins, National Board Member, American Medical Technologists (AMT). On behalf of AMT and its registrants, I wish to thank you for the opportunity to present this statement before you today.

AMT is a National Registry of Medical Technologists, founded in 1939 and headquartered at 710 Higgins Road, Park Ridge, Illinois. Current registration is in excess of 10,000 persons, most of whom are presently working in laboratories throughout the country and are engaged in the testing of specimens to assist in the detection of human disorders. Our registrants include college and vocational school graduates, as well as several thousand veterans, most of whom were trained in Armed Forces schools of medical technology.

AMT, through an autonomous agency, the Accrediting Bureau of Medical Laboratory Schools, is a national accrediting agency recognized by the United States Office of Education, pursuant to Public Law 82-550 and subsequent legislation. The Bureau operates only in the field of medical laboratory technician education. (See Federal Register, vol. 35, no. 96—Saturday, May 16, 1970.)

The Registry itself, as opposed to the Bureau, is concerned with technologists as well as with technicians, and it registers persons in both those categories on the basis of their having met certain educational standards and having passed difficult and comprehensive examinations. A detailed statement of AMT's registration requirements for technologists and technicians is attached here as Appendix 1. Attached here as Appendix 2 is a list of the required courses for the grade of technician. I request that these appendices be recorded in the record following this statement.

One indicator of the adequacy of our requirements, apart from the USOE recognition, is the fact that accredited hospitals, pathologists, physicians, and independent laboratories aggressively recruit technologists and technicians registered by AMT. Many of our registrants, incidentally, are employed in laboratories in the Washington area, and included among these are Bethesda Naval Hospital and Walter Reed Army Hospital.

My purpose in appearing before you today is not to oppose anything presently in the Medicare Statute. I am here to call to your attention serious and dangerous deficiencies in the administration of the Medicare Act: the arbitrary exclusion of qualified persons from the grade of technologist under the regulations entitled *Conditions for coverage of services of independent laboratories* (*Code of Federal Regulations, Title 20, Chapter III, Part 405*) adopted pursuant to 42 USC § 1395x(s) (10) and (11). These provisions of the Statute empower the Secretary of HEW to impose conditions relating to the health and safety of individuals (Medicare patients) with respect to whom medical laboratory tests are to be performed. The Conditions apply only to independent laboratories and not to hospitals or to laboratories in physicians' offices.

From the inception of Medicare the personnel of the United States Public Health Service, who were assigned the task of drafting the Conditions, have set very arbitrary personnel standards for technicians and technologists permitted to work in Medicare labs. For instance, the AMT standards for technicians (see Appendices 1 and 2) were denied recognition, yet the standards for the Certified Laboratory Assistant Program sponsored and recognized by American Society of Clinical Pathologists (ASCP) and American Medical Association (AMA) was recognized. This is so despite the fact that the CLA program of ASCP and AMA is not claimed by its sponsors to be an educational program for technicians, but merely for laboratory assistants.

A glance at the comparative standards of the CLA program and the AMT technician program will explain the modesty of ASCP and AMA in not claiming technician status for their CLA program. The AMT program is based on 1,500 clock hours of instruction with at least 6 months working experience following the instruction, while the CLA program is based on a minimum of 100 clock hours of classroom-type instruction, either followed by or intermingled with sufficient weeks of on-the-job training to round out a full year. The AMT program requires a minimum of one year of school followed by one year of on-the-job training, or, in the alternative, 18 months of actual school followed by 6 months of on-the-job training. In other words, the AMT program, which is under the jurisdiction of the Accrediting Bureau and, therefore, approved

by USOE, is twice as long in total duration and 15 times as long in minimum classroom requirements as the CLA program. Yet the two programs are considered on a par as far as the Medicare Independent Laboratory Conditions are concerned.

I might add that the Conditions themselves do not mention the AMT, the Accrediting Bureau, or its programs, but do mention and approve, at the technician level, the CLA program, despite the fact that the Bureau-approved program is approved by the USOE and the CLA program is not. However, we are not primarily concerned simply with being or not being mentioned by name in the Conditions (though the injustice of our exclusion is obvious), but we are concerned about the philosophy of the Medicare Administration which for a period of several years has only reluctantly conceded that anyone other than AMA might have something of value to contribute to the advancement and protection of the public health. It happens that AMT and the Accrediting Bureau are now included in the manual furnished at the state level to inspectors dealing with independent laboratories doing work on Medicare patients. Exactly why the AMT and the Accrediting Bureau can be mentioned in a manual distributed only to officials, but not in a manual on the same subject distributed generally, is not apparent. (The reason given by USPHS personnel involved with this problem is that the AMT Bureau has only "provisional" USOE recognition granted in the fall of 1969. Nevertheless, all USOE recognition of accrediting agencies is always subject to review and the ASCP–AMA program for CLA education lacks even provisional approval by USOE.)

Of even more serious concern, however, is the arbitrary decision on the part of the Medicare and USPHS bureaucracies to divide labortory personnel below the grade of supervisor into two categories: technologists and technicians, on the basis of artificial standards. As will be noted in the appendices, the AMT standards for technologists permit a person to register as a technologist in several ways, including a route of upward progression from the grade of registered technician (MLT) to that of registered technologist (MT) on the basis of proper qualifying experience in a proper laboratory and the passing of a difficult and comprehensive examination. The failure of the Medicare Administration to recognize the validity of such upward progression contributes, in our opinion, to the dire shortage of skilled laboratory personnel and to the wholesale abandonment by laboratory personnel of their intended laboratory careers.

We believe that your Committee may have attempted to have the Secretary of HEW treat with this problem of arbitrary exclusion of competent personnel from laboratories via arbitrary personnel standards when it adopted the report designated as S. Rep. No. 744, 90th Cong., 1st Sess. (1967). In that report the Committee incorporated a directive to the Secretary of HEW stating the Committee's concern with the dire shortage of personnel aggravated and partially caused by arbitrary educational and other requirements by saying

> . . . that the reliance placed specific formal education, training, or membership in pravate professional organizations might sometimes serve to disqualify people whose work experience and training may make them equally or better qualified than those who meet the existing requirements. Failure to make possible the fullest use of properly trained health personnel is of particular concern because of the shortages of skilled health personnel in several fields.

In the next paragraph of the report the Committee directed the Secretary to "engage in consultation with appropriate professional health organizations and state health agencies and to the extent feasible, *explore, develop*, and apply appropriate means of determining the proficiency of health personnel *disqualified* under the present regulations." (Id., emphasis added.)

Only the most perfunctory study and review of this matter was given to this problem by the Secretary prior to Secretary Cohen's report to the Committee transmitted by letter dated December 28, 1968, to the Honorable Russell B. Long, Chairman of the Committee on Finance. The report accompanying Secretary Cohen's letter was entitled "PERSONNEL QUALIFICATIONS FOR MEDICARE PERSONNELL: A Report to the Congress".

Other studies, particularly those of Dean S. Ammer, "Productivity, Personnel, and Problems of Hospital Clinical Laboratories" (supported by an HEW grant RO1 PM 00001, Division of Physical Manpower Bureau of Health Manpower) and of Professors Morris A. Horowitz and Harold M. Goldstein ("Hiring Standards For Paramedical Manpower", prepared under Grant No. 91–23–67–57) deal with this problem in a manner supporting the position of AMT. The substance of these reports is that there is really no difference in a working labora-

tory between a technician and technologist, or between the work and tests performed by them. The latter report recommended, among other things, that

6. The Government (local) should examine the whole practice of licensing of the various paramedical occupations, a practice which has tended to exclude disadvantaged and school dropouts by means of arbitrary and unnecessary qualifications. (p. xi).

8. Wherever possible hospitals should develop a job promotion ladder, with the necessary training furnished on the job. Thus, by eliminating dead end jobs and creating promotion opportunities, hospitals will attract better personnel and reduce attrition. (p. xi).

Quite obviously the Medicare laboratory regulations were the very type of stifling regulation which Professors Horowitz and Goldstein recommended be eliminated. We feel it significant, and frustrating both to the advancement of the public health and to efficient administration of Government, that the draftsmen of the Medicare personnel standards ignored completely studies bankrolled by the Government to seek a solution to a problem which the Government recognizes, but which one part of the Government (the Medicare draftsmen) seems dedicated to preserve.

A very recent study sponsored by the National Committee for Careers in Medical Technology (under Public Health Service Contract PH–108–66–151) attempted to discover reasons for career abandonment by laboratory personnel and to develop and implement means of attracting former laboratory personnel back into the field. A report by Norman E. Holly (health economist in the Office of International Health, Office of the Secretary, Department of Health, Education and Welfare) entitled "A Matching Program to Retrain Inactive Medical Technologists" appearing in *Public Health Reports* vol. 85, no. 8, August, 1970, p. 666 et seq., shows that even diligent, well-financed efforts to attract workers back into the lab once they had left were idle. It is obvious to us in the field that the way to cure the shortage of laboratory personnel is to make the work attractive enough that they will not leave in the first place. Very obviously the arbitrary labeling of a worker as a technician when he should be promoted to the grade of technologist will not tend to make him pursue a lifetime career of laboratory work. This fact is particularly pointed up by the arbitrary designation as technicians under Medicare of persons trained in Armed Forces laboratory schools. There, under a 50-week program, virtually identical to the AMT technician program, the personnel are trained to be "*in charge of* military medical laboratories" (emphasis added) ("program of instruction for 311–92B30 medical laboratory procedures (advanced) course, mos: 92B30," approved by the Surgeon General of the Army, July 11, 1967), yet the Medicare standards do not permit them, on the basis of that training, to rise higher than the very lowest grade recognized under the standards: that of technician, and at that, on a par with and no higher than laboratory assistants.

Of course, this improper and arbitrary handling of laboratory personnel in the Medicare Conditions could be prevented by statutory amendment. However, we do not suggest that to be a proper course, particularly since the standards need to be reviewed and upgraded from time to time. Rather, the problem should be solved by careful and conscientious review by the Secretary of HEW of the present arbitrary and stifling personnel conditions. Such a review was specifically suggested by this Committee in its report during the 90th Congress (S. Rep. No. 744, 90th Cong. 1st Sess. (1967)).

American Medical Technologists is always carefully studying and reviewing its own standards and, in keeping with the advances of laboratory science, is upgrading them both (1) to meet the legitimate career expectations of qualified personnel and (2) to protect the interests of the public in having only qualified persons performing laboratory tests. The Medicare Administration should do no less, but so far it has effectively done neither.

Elimination from the Conditions of personnel standards for technicians and technologists would be an improvement over the present Conditions. (With the CLA program being included, there are no effective technician standards anyway.) Adoption of standards providing for upward career progression would be a suitable and effective alternative improvement.

RALPH S. HASKINS, A.M.T.,
National Director.

Appendix 1

A medical technologist is a person qualified by education and experience to perform clinical laboratory testing requiring the exercise of independent judgment and discretion.

A medical technologist is qualified to supervise technicians and laboratory aides and to assist in their training. A technologist may perform tests and report results under general supervision and may do so when the laboratory director or supervisor is either on duty or on call.

A technologist may calibrate equipment and, in consultation with the laboratory director, assist in determining the accuracy and utility of new tests and procedures.

Depending upon the education and training of the individual, a technologist's area of competence may be limited to one or more branches or specialties of the medical technology field.

1. Applicant must be a citizen or resident of the United States, or any dependency, or of any other Western Hemisphere nation, and must be of good moral character.

2. Applicant must be a high school graduate or acceptable equivalent.

3. All applicants for certification by A.M.T. as an M.T. must meet one of the following requirements:

a. Professional school/armed forces school/two-year college program: Applicant must meet the requirements for M.L.T. and must have three (3) additional years of approved laboratory experience.

b. College or university: Applicant must have completed 90 semester hours in an accredited college. This can include junior college credit, and must include 40 semester hours in the sciences. This must include the following specific course requirements or the substantial equivalent: 12 hours in chemistry; 12 hours in bacteriology and/or parasitology; 6 hours in mathematics; and 8 hours in biology, genetics, embryology, zoology, or anatomy, or

c. Applicant must hold at least a bachelor's degree in medical technology or a bachelor's degree with a major in one of the biological science from an accredited college or university.

In addition, all applicants must complete at least one year of approved laboratory experience.

4. All applicants must take and pass the A.M.T. registry examination for the certification of M.T.

Note: An applicant may qualify for registration as a Medical Technologist on the basis of having graduated from an A.M.T. approved school prior to November 1, 1965, and having at least four years of approved laboratory experience.

A medical laboratory technician is a person qualified by education and experience to perform clinical laboratory testing requiring minimal exercise of independent judgment and discretion.

A technician ordinarily works only under immediate supervision, particularly when performing tests of other than a routine nature. A technician may perform tests and report results of routine procedures without close supervision, but only if a technologist or other person of higher qualification is on duty in the laboratory or on immediate call.

1. Applicant must be a citizen or resident of the United States, or any dependency, or of any other Western Hemisphere nation, and must be of good moral character.

2. Applicant must be a high school graduate or acceptable equivalent.

3. All applicants for certification by A.M.T. as an M.L.T. must meet one of the following requirements:

a Professional school training: Applicant must be a graduate of a medical laboratory school (offering a 12 or 18 month course in medical laboratory techniques) accredited by the Accrediting Bureau of Medical Laboratory Schools. In addition, the applicant must complete enough approved laboratory experience to make his combined school and laboratory experience program at least two years in length. A list of accredited schools can be obtained upon request.

b. Armed forces school: Applicant must have completed a course of at least one year (50 weeks) in a U.S. Armed Forces school of medical laboratory techniques. The school's courses must be the substantial equivalent of the courses offered in a school accredited by the Accrediting Bureau of Medical

Laboratory Schools. In addition, the applicant must complete 12 months of approved laboratory experience.

c. College, university, or junior college: Applicant must have completed 60 semester hours in an accredited college or junior college, including at least 25 semester hours in the sciences. This must include the following specific course requirements or the substantial equivalent: 12 hours in chemistry, bacteriology, or parasitology in any combination; 3 hours in mathematics; 8 hours in biology, genetics, embryology, zoology, or anatomy in any combination, or

Applicant must be the holder of an associate of science degree in medical technology, or equivalent) from an accredited junior college.

In addition, all applicants must complete 6 months of approved laboratory experience.

4. All applicants must take and pass the A.M.T. registry examination for the certification of M.L.T.

5. The experience requirements need not be completed when the application is filed.

APPROVED LABORATORY EXPERIENCE

All approved laboratory experience credited toward certification must be:

1. In a Clinical Laboratory meeting one of the following requirements:

a. Directed by a person holding an earned doctorate degree in one of the sciences

b. Approved for service to patients under "Conditions for Coverage of Services of Independent Laboratories" under Medicare, or

2. In a Research Laboratory meeting one of the following requirements:

a. Operated by an accredited college or university

b. Directed by the holder of an earned doctorate degree, or

3. In a Hospital Laboratory meeting one of the following requirements:

a. Accredited by the Joint Commission on Accreditation of Hospitals

b. Accredited by the Bureau of Hospitals of the American Osteopathic Association

4. The laboratory experience must cover at least four (4) of the various branches of clinical laboratory testing (e.g.) chemistry, hematology, parasitology, urinalysis, bacteriology, serology, blood banking, etc.

APPENDIX 2

MINIMUM COURSE REQUIREMENTS OF AMERICAN MEDICAL TECHNOLOGIST ACCREDITED SCHOOLS

Formal training in an AMT accredited school may be completed in either an 18 month school plus a 12 month internship program, or in an 18 month school plus a 6 month internship program.

REQUIREMENTS FOR 12 MONTH SCHOOL PROGRAM

	Lecture hours	Lab hours
Anatomy and physiology	20	10
Medical orientation	10	10
General chemistry	30	60
Hematology	60	140
Bacteriology	60	120
Parasitology	40	80
Urinalysis	25	55
Gastric analysis	5	5
Clinical chemistry	80	160
Serology	30	70
Histological techniques	30	60
Basal metabolism and electrocardiograph	10	20
Blood banking	20	40
Medical ethics	15	0
Advanced laboratory procedures, seminars, etc	20	80
Total	455	910

The student must also successfully complete such additional elective courses as shall cause the total clock hours to be not less than 1500.

REQUIREMENTS FOR 18-MONTH SCHOOL PROGRAM

The student must successfully complete all the courses required for the 12 month program. Additional hours in these required courses and courses selected from the following list must also be taken to complete 2100 clock hours of instruction:

	Lecture hours	Lab hours
Biology	30	60
Zoology	30	60
Chemical arithmetic	60	0
Elementary physics	20	32
Mycology	15	45
Virology	15	45
Business English	55	0
Total	680	1,152

RECAPITULATION

Total clock hours required for 12 month school: 1500.
Total clock hours required for 18 month school: 2100.

Mr. HASKINS. Thank you.

The CHAIRMAN. It is my understanding that the Department ignored the testing program that the committee recommended.

Mr. HASKINS. Yes, sir; to my knowledge they have ignored it.

The CHAIRMAN. Do you have schools training young people to be technicians?

Mr. HASKINS. A 2-year program.

The CHAIRMAN. I see. How much education do they need before they enter?

Mr. HASKINS. High school or the equivalent.

The CHAIRMAN. So you are training young people, not to be doctors but to be technicians and do work that a doctor need not have to do if someone can do it for him?

Mr. HASKINS. Yes, sir.

The CHAIRMAN. I see.

Is appendix 2 a list of things that you expect these technicians to know?

Mr. HASKINS. Yes, sir.

The CHAIRMAN. It would seem to require that this young person would have to spend a large amount of time. I read an article of a young person who had been in the service who was working as a doctor's assistant in some capacity now.

It looked as though that might be one way to help provide the personnel and help hold down the costs of medicare. How much additional training does a young person of that sort need in order to go to work doing laboratory work or as a corpsman or a doctor's assistant?

Mr. HASKINS. Well, a goodly portion of those people are trained to run laboratories in the absence of a physician, so they are highly qualified.

The fact is initially when we first started working on this problem the military people were excluded right along with us. Our program of training is equivalent to that of the military.

The CHAIRMAN. It would seem to me that when we draft a young man or even better when he volunteers and qualifies himself to be a medical corpsman, that we ought to have a program available where

persons of that sort could quite readily find themselves a place in our civilian economy by qualifying themselves to do work parallel to what they had been doing for the military.

Those types of health services are needed, are they not?

Mr. HASKINS. Yes, sir.

The CHAIRMAN. How much additional training do you think a fellow needs if he has been a good medic in the military, in order to find himself a place in a hospital or in the health care field?

Mr. HASKINS. Mr. Yoder.

Mr. YODER. Let me, on Mr. Haskins' behalf or by way of assisting him, attempt to answer that.

This program for medical technicians that is contained in appendix 2 to Mr. Haskins' statement is virtually identical to the 50-week Armed Forces training program for military medical laboratory personnel, the manual of which states that they are trained under this program to be in charge of military medical laboratories.

For a young man to come out of the service having had that training and having served his hitch to go into the laboratory in civilian life needs no further training unless his field experience or his Army hospital experience was so specialized that he might need to brush up on other things. But the answer is none, exactly none.

The CHAIRMAN. Well, in view of the cost, and lack of availability of medical care, it seems rather ridiculous to decline to use young people whom we have trained in the military and who have done their tour of duty for their country, and who then seek an opportunity to serve their fellow men in civilian life.

Mr. YODER. Well, Mr. Chairman, those militarily trained people are now included in the technician category under the medicare regulations.

I might say that was largely due to the efforts of Mr. Haskins and his colleagues in coming up here over a period of many months and a couple of years and fighting for the inclusion of that which HEW finally did go along with. Many of AMT's registrants were in the service.

However, they are denied the opportunity to progress upwards from the grade of technician, which is a subservient role in the laboratory, to that of technologist who works under lighter supervision, even though the Army states they are trained to be in charge of military medical laboratories, and I am quoting directly, as you will see, from Mr. Haskins' prepared statement, from the language of the Army Training Manual, itself.

So it is a waste of human resources, as I think you have indicated in your comments.

Mr. HASKINS. Another thing, Mr. Chairman, significant to this is that these military people, as well as our people, are hired at a much lower salary level and kept there rather than advanced according to their ability to perform a certain function in the laboratory.

The CHAIRMAN. It seems to me we ought to try to do something about all the mentally ill who are not being treated today, many of whom could be restored to a productive life.

A lot of them are not going to be able to work at gainful employment, but a lot of them can, I should think at least half of them could

be restored to adequate mental health and could work and earn their own way and be taxpayers rather than tax consumers.

To do that we will probably be told that we cannot find the doctors and that it would take years to train that many doctors, if you are going to start with a 4-year medical course, and then have specialty training from that point forward. But if you use corpsmen and medical technicians of various types, who can do things that a doctor need not necessarily do, then you should be able to find a lot more doctors to help in the care of the mentally ill and other things.

Mr. YODER. Mr. Chairman, we have urged that position on HEW ever since I have been associated with this organization in attempting to do something about these Medicare regulations.

The Government has spent, I suppose, millions on trying to discover and devise ways to get people who once worked in clinical laboratories and left the field to come back in or who have been trained in them to stay in, and they have not been able to do much about it.

A recent report by a Federal employee, a Mr. Norman E. Holly, which is mentioned at page 9 in Mr. Haskins' statement, displays the futility of getting somebody back in once they have left.

However, these medicare conditions force people out, I think as Mr. Haskins indicated, by keeping these—for instance, these Armed Forces highly skilled and well trained people, and other capable personnel, from rising above the technician level to that of technologist, for which level they are, in fact, trained.

Now, there is a tyranny of labels here. The Army will say, "No, we train technicians." Nevermind what they call it, they train them, they state they train them, and in practice they put them in charge of military medical laboratories, call it what you will.

Now, in fact a technician in medicare is a lower type person than a technologist. However, also in medicare, the draftsmen of the conditions have seen fit to call American Medical Association-approved laboratory assistants (CLA)—AMT does not have any similar category—to give them the grade of technician. This puts them on a par with somebody who went to school for a year or more, as those in the Army and others of our registrants have, when the CLA went to school for 100 hours.

Mr. HASKINS. That is right.

Mr. YODER. It is not that the medicare standards for technicians are too high, it is that these standards are arbitrary. They let some people who are not qualified in and they keep others who are qualified out.

Mr. HASKINS. Right.

The CHAIRMAN. I personally am satisfied with the level of Government care provided for U.S. Senators. If I need to have a shot of something or other, I go and check in with Dr. Pearson over here at the Senate Dispensary, and if he decides that they ought to give me a shot he tells a medical corpsman to give Senator Long a shot, and the medical corpsman gives me the shot, and that is the end of it.

A doctor does not do that, and I personally would favor a regulation that he does not stick the needle in anybody. He just tells the corpsman to do it, and that is the corpsman's job.

If he has need to take a blood sample, the corpsman takes the blood sample. The doctor does not have to do that. His time is too valuable,

he is too busy, to have him doing something that a nurse or hospital corpsman can do just as well.

Mr. YODER. Senator the chances are—I do not want to say overwhelming, but excellent, that that man that you see who takes that blood sample from your body may well be one of our registrants. We do not ever mention names for ethical reasons, but I do happen to know that one of the primary draftsmen of one of these medicare regulations is always being taken care of by one of these people, and he has always stated to me he does not think anybody is competent unless they are under one of these AMA-approved programs. He does not know it, but one of our people takes care of him.

The CHAIRMAN. Is it really established practice that the doctors have these technicians do the tests for them rather than the doctor doing it himself?

Mr. YODER. In almost all instances the doctor confines himself, and should because of his high skill, to difficult cases, to tissue analysis, to—I am getting out of my field, Ralph, I think you had better take that back.

Mr. HASKINS. Usually the medical technician or medical laboratory technologist, whichever term you prefer to use, performs the diagnostic procedures in the laboratory. In histopathology, for instance, he cuts the tissue, stains it, and so forth, and gives it to the pathologist who would read it rather than a pathologist doing all of the preparatory work, the work in preparing the specimen for the pathologist to read. This is done by people in the histo group.

This same thing is true in the clinical chemistry laboratory. While you may have a pathologist who is the director of the laboratory, the work itself, and the planning and all of that is done by people of a technologist or technician's category. It is also quite interesting, that very often a pathologist who directs a clinical chemistry laboratory that is automated may not know anything about the automation, and he depends upon people like me to do that for him.

The CHAIRMAN. Yes.

Well, thank you very much.

Any further questions?

Mr. HASKINS. Thank you.

The CHAIRMAN. Our next witness will be Dr. Robert W. Gibson, medical director, the Sheppard and Enoch Pratt Hospital of Towson, Md., on behalf of the American Psychiatric Association.

If he is not here, then we will print his statement.

(The statement of Dr. Gibson follows:)

TESTIMONY SUBMITTED ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS BY ROBERT W. GIBSON, M.D., MEDICAL DIRECTOR, THE SHEPPARD AND ENOCH PRATT HOSPITAL, TOWSON, MD.

Mr. Chairman and Members of the Committee, I am honored to have this opportunity to speak to you on behalf of the American Psychiatric Association, whose 18,000 members have the primary responsibility for the medical treatment of the mentally ill in our country, and to speak on behalf of the National Association of Private Psychiatric Hospitals, whose 134 member hospitals have the primary responsibility for the private hospital care of the mentally ill.

As psychiatrists, we are indebted to the members of this Committee for their continuing interest in those provisions of the Social Security Legislation affecting psychiatric care. And, and we are particularly grateful to your Chairman, Senator

Long, for his personal efforts. The mentally ill are neither articulate nor effective spokesmen in their own behalf and it is indeed fortunate that in Senator Long they have a dedicated champion, sensitive and concerned about their needs.

Gentlemen, I speak to you today with grave concern and disappointment about the legislation before us. It does nothing to eliminate the discriminatory provisions of Medicare and Medicaid. In fact, Section 225 singles out the mentally ill for even further limitations under the Medicaid program by a decrease in Federal matching of one-third after 90 days of care in mental hospitals and provision for no Federal matching after an additional 275 days of such care during an individual's lifetime.

In testimony presented before this Committee some three years ago, I asked for the elimination under Title XVIII of the special financial limitations placed on psychiatric outpatient treatment.

I asked for the elimination under Title XVIII of the 190 lifetime limit placed on treatment in a psychiatric hospital.

Three years ago the reluctance to act on these recommendations because of the deep-seated concern about the overall costs of the Medicare and Medicaid programs was understandable. The apprehension about the *total costs of the programs* was shared even though I did not believe that our recommendations regarding psychiatric benefits would create fiscal problems.

But now, three years later, there is evidence that the concern about costs of psychiatric care is not warranted. In 1968, based on claims paid under Medicare, payments for psychiatric hospitalization represented only 0.7% of the total amount reimbursed and the suggested changes would add little if anything to this.

I will review only briefly the recommendations concerning outpatient treatment under Title XVIII. Under the supplementary medical insurance benefits for the aged, outpatient treatment may be paid for after a $50 deductible, with the patient paying 20% and with no top limit, *but in the case of psychiatric treatment*, the patient must pay 50% after the deductible, and there is a top limit of $250. This limitation seriously curtails outpatient treatment for the aged patient. In many instances the limitation will prevent the adequate outpatient evaluation and screening that have been shown to decrease unnecessary hospitalizations. The retention of this limitation on psychiatric outpatient services is particularly incongruous in the light of comments on page 38 of the Report of the Committee on Ways and Means on H.R. 17550 noting a wish "to encourage states to make more efficient use of health services" and a wish to "create incentives to encourage outpatient services and disincentives for long stays in institutional settings."

Thus, I ask for the elimination of discriminatory provisions limiting outpatient psychiatric care for the treatment of the aged under Title XVIII.

This would mean deleting the phrase "(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is smaller: (1) $312.50 or (2) 62½% of such expenses." P.L. 89-97, Title XVIII, Section 1833(c).

Again addressing myself briefly to Title XVIII, there is a 190 day lifetime limit placed on treatment in a psychiatric hospital. No such limit is placed on treatment in a general hospital, even if such treatment in the general hospital is for a psychiatric illness. It makes no sense to force a patient to shift from one institution to another and that is exactly what can happen. Only infinitesimal financial savings could be achieved through this limitation and in fact it is possible that by forcing patients into more expensive general hospital beds this 190 day lifetime limitation is increasing the costs to the program.

Therefore, I ask you to eliminate the 190 lifetime limit on treatment in a psychiatric hospital under Title XVIII.

This would mean deleting the phrase "(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime." P.L. 89-97, Title XVIII, Section 1812(b).

In its Annual Report on Medicare, the Health Insurance Benefits Advisory Council recommended the enactment of legislation which would allow the participation of community mental health centers in the Medicare program. Mental health centers that are affiliated with general hospitals are certified under Medi-

care as part of the general hospital; centers that are affiliated with a psychiatric hospital are certified as part of that hospital. But, a number a new centers have developed independently and are free standing. To qualify as a Medicare provider for service and receive reimbursement for inpatient care, present law requires that the free standing mental health centers meet the conditions of participation for psychiatric hospitals.

We urge the enactment of legislation that would allow the participation under Medicare of all qualified community mental health centers. This is consistent with the development of such centers throughout the country to provide more comprehensive treatment services, accessible to the population groups served.

To accomplish this, the inpatient services in these centers could be covered under Part A of the program, subject to the same conditions and limitations as are applicable to inpatient psychiatric benefits. Payment for outpatient services could be made under Part B, on a reimbursable cost basis in *much the same manner* as outpatient hospital services.

Turning now to Title XIX, medical assistance is provided for persons under 65 who are in families with dependent children, are blind, or permanently and totally disabled, and whose incomes and resources are insufficient to meet the costs of necessary medical services. Recipients under the age of 65 may receive inpatient psychiatric treatment on the psychiatric unit of a general hospital, but *not* in a mental institution, whether it be a public or a private mental hospital, or even a community mental health center.

This limitation is highly objectionable. Not a single state in our country has a sufficient number of psychiatric units in general hospitals to treat the persons now eligible for benefits under Title XIX. Furthermore, the psychiatric unit of a general hospital provides only a limited spectrum of care—primarily diagnostic and brief stay. They seldom have the full range of specialized mental health professionals, and the shortage of facilities and staff to treat children is particularly severe. Treatment in a public mental hospital, a private psychiatric hospital, and a community mental health center was included by the Congress under Title XVIII and the failure to do so under Title XIX is fundamentally inconsistent with the emphasis on community phychiatry so vigorously supported by the Congress.

To do this, you must include all the properly qualified institutions. We want the definition of a hospital to include the public mental hospital, the private psychiatric hospital, and the community mental health center.

This would mean deleting the phrase "other than services in an institution for . . . mental diseases." P.L. 89–97 Title XIX, Section 1905(a)(1).

I would now like to refer to Section 225, of HR 17550, which increases by 25% the Federal medical assistance available for outpatient hospital service and clinic service, but also provides:

"after an individual has received inpatient services in a hospital for mental diseases on 90 days occurring after December 31, 1970 (whether or not such days are consecutive) the Federal medical assistance percentage with respect to any such services furnished to such individual on an additional two hundred and seventy-five days (whether or not such days are consecutive) shall be decreased by 33⅓ per centum thereof and no payment may be made under this Title for any such services furnished to such individual on any day after such 275 days."

As indicated in the Report of the Committee on Ways and Means of HR 17550:

"The proposal to increase the Federal matching for outpatient, clinic and home health services is directed at encouraging the States to provide early diagnosis and treatment of illness, preventive services, and alternatives to institutional care intended to reduce the need for and use of inpatient services.

"The proposed limitations on length of stay in mental institutions reflect the assumption that medical treatment of mental illness inpatients generally does not exceed three months and for patients over 65 rarely continues beyond a year."

Outpatient services should be encouraged not only because they are more economical but because when used appropriately they are in the best interests of the patient. The assumption that treatment of psychiatric inpatients does not exceed three months is a generalization and over-simplification. In previous testimony I have indicated that many elderly patients do respond to an active treatment program in less than 90 days, but there also are significant numbers that need care over a prolonged period. Arbitrary and inflexible limitations such as those proposed will unquestionably deprive many patients of needed treatment.

It must be noted that a high percentage of elderly patients in mental hospitals are suffering from significant degrees of physical impairment and do receive needed medical treatment. Limiting the Federal medical assistance available to hospitals for mental diseases would encourage shifting such patients to more expensive medical and surgical institutions where, incidentally, the psychiatric needs would not be adequately met.

Admittedly some States have not effectively utilized the Medicaid funds available for psychiatric services. Nevertheless, these programs do have meaningful potential and it would be a disservice to disqualify all in one sweeping judgment. In attempting to eliminate those programs that are not delivering effective services, it would be preferable to insist on more adequate documentation of services rendered and to intensify utilization review.

A further limitation in Section 225, affects skilled nursing homes:

"(B) after an individual has received care as an inpatient in a skilled nursing home on 90 days (whether or not such days are consecutive) during any calendar year, the Federal medical assistance percentage with respect to any such care furnished thereafter to such individual in the same calendar year shall be decreased by 33⅓ per centum thereof;"

This limitation will only intensify the plight of the elderly person suffering from mental illness because many such patients with lesser degrees of mental impairment are being cared for effectively in the skilled nursing homes. This further withdrawal of support for older persons with psychiatric disabilities would be most unfortunate.

In brief, I strongly favor the increased Federal medical assistance being made available for outpatient service but oppose those reductions and lifetime limitations on the assistance available for inpatient services in a hospital for mental disease and the curtailment of assistance for skilled nursing home care.

Our associations ask for an insurance benefit system that would enable the profession of psychiatry to provide the full range of psychiatric treatment to all persons deemed eligible and to do so on an effective basis. We look forward to the opportunity to work collaboratively with the Federal Government in achieving this. We pledge our wholehearted support to the Congress and to the public and private agencies in making such an equitable system fully workable and maximally effective.

The CHAIRMAN. I would like to ask that the statement of Dr. Lloyd Cunningham of Lafayette Day Nurseries, Inc., Lafayette, La., be printed as though read in the record at this point.

I informed Dr. Cunningham that it would not be possible to schedule additional witnesses, and that I very much applauded his statement, particularly in view of the fact that his statement supports a bill that I have introduced, I would like to have it appear in full as presented.

(The statement of Dr. Cunningham follows:)

STATEMENT TO SENATE FINANCE COMMITTEE ON WEDNESDAY, SEPTEMBER 16, 1970, BY LLOYD G. CUNNINGHAM OF LAFAYETTE DAY NURSERIES, INC., LAFAYETTE, LA.

Without fanfare the people of Lafayette, Louisiana have been giving working parents the opportunity to go to work to improve their family income without worrying about improper child care at home. This preschoolers' care has been going on for the past 22 years—long before such programs were in vogue elsewhere in the South.

The Lafayette Day Nurseries, Inc. has provided its own head start education program a community awareness curriculum with city-wide field trips, hot noon meals, two daily snacks, and qualified teachers. This has all been accomplished with private funds. Parents of the children have been given the dignity of participation through minimum fees that they pay to the school with assistance, if necessary, from state welfare programs.

Also, mothers and fathers have participated in raising funds through gumbo suppers, barbecues, and other projects. Some of the parents have made gifts of their time and skills through carpenter work, brick-laying, and painting.

There is pride in the Lafayette community for the school that has been supported by the parents, women's clubs, men's civic organizations, the Boys Scouts

of America, University of Southwestern Louisiana fraternal organizations, city government, and others.

We are baby-sitting with 2-to-5-year old children of working mothers, it is true. But we are also making good citizens for the future.

In the 22 years we have developed the mechanism for our society to provide the first class kind of care our society needs for its children. Private and tax dollars have been used to help us in this very real need—a need which is truly universal—to pick up the child and lift it into a gainful and law abiding niche.

This law of Senator Long's, Federal Child Care Corporation, is needed for it would provide money to work with the child while very young. The earlier the better for he is very impressionable and can be helped far easier and cheaper. The very fact that the child is removed from the home for the day is often its very salvation. Whatever the home situation—the alcoholic, neurotic, unwed mother, or a happy one—the child will go further faster.

With licensing only being given to the care centers that meet standards set for adequate space and staffs, then the child will bloom. Health requirements go hand in hand with the first two. We have found that once a child is enrolled into care centers, it is very easy to move rapidly into improving his health. Through the University of Southwestern Louisiana Speech and Hearing Clinic, through special education, the guidance center and the youths of the medical profession, we surmount our obstacles.

The unlicensed facility is all too often the money machine for its operator. These must be outlawed quickly for most often they are the beginning of a one way road of indifferent care. This type of road often has a policeman at its end. The child care facility needed to provide for this nation's children are great indeed. The very working capital that would be provided through this bill would make it feasible for most communities to help themselves. Let me not fool you—for all but our last four years we were not the most desirable of child care centers. The Welfare would speak of any operation such as ours as being near substandard. We did provide the mother image, care, hot meals and an ideal situation away from home for the child. This in a frame house of re-claimed and gift furnishings.

Two nurseries were operated by us with a pot and a pan each, left over or even broken toys, cast off dress-up clothes, and with an underpaid but willing staff. Meetings of the board used to be about our need of soap, food, clorox, and toilet paper. Do you know what it means to be down to your last roll with 60 kids who are biologically functioning well?

A bill of this type would make it possible for a group, a corporation or an individual to put together a human need with care and education. The money would be available for the child care center that could meet the license requirement—not once but daily. This would jump a generation and meet head on the long problem which is national in scope. The cost of care at this age is nothing in comparison to penal care of one at a later age.

This summer we entered the day care field in conjunction with the Win Program, with an average of 40 boys for 12 weeks. I obtained 20 acres on a 20 year lease from Texaco with an option for 20 more years. With a university clinic teacher and an assistant principal, both have a master's degree, and two college boys, we were staffed. Two port-o-lets took care of our sewer system. 136 Army Reservists spent the day clearing 6 acres with a medium-sized bulldozer that they paid for, which worked a day and a half. At a later date, I entered into a working agreement whereby a bulldozer and grader worked one weekend, labor was the only cost on this Parish-owned equipment.

Last summer I asked for and was given a 1915 Ft. Worth and Denver caboose 40 feet in length and red. With this converted into a kitchen, we raised money by going to shows and fairs. This was used by us along with a lean-to for our camp. Imagine what a bill could have provided for us.

Our present day care center is due to three local banks joining us to provide a facility to meet the needs of the individuals on the local level. It is due to our being able to expand that we could meet our financial obligations in this center. We provide day care for 94 2–5 year old children from 7:00–4:00, active probing play, morning snack, meal, rest, afternoon snack, $10 weekly.

This summer our day center boys 8–16 were packed up at 7:15 and bussed 8 miles to play—morning snack, luncheon, rest for one hour, afternoon snack, and left for home at 3:30. We felt if boys worked in and about the camp one hour a day, they would not only improve it and build it but develop an identification with it. This was an immediate success. $17 weekly for care. The end results for our community are felt with many pluses. While these boys were growing their

mothers were learning more jobs to increase the family income. There were five that through their schools will be taken to the guidance center for evaluations for they are emotionally disturbed. In this manner we utilize both private and governmental agencies to help the child in our care.

Think what a bill like this would do. We have the organization and capability of meeting a child's needs in day care in a responsible manner. There is an abundance of children. Put these together and we could have a pilot program. Our board has been caring for the last three years to meet more of the needs of our community. We find the need and then study it and then act upon it. At present there is one camp set up for 2 weeks for retardates in Louisiana. We are now doing a study on a pilot program within the frame work provided for us by Dr Faulk, head of Special Education for USL. Here again, we will get the necessary tools and put them to work.

With the help of a bill like Federal Child Care Corporation contracted relationship could be entered into with a non-profit corporation such as ours on behalf of children. There is no reason to water down the school systems in any area to the level of the mass. Lift the vast mass and we lift all. This is our country and we have it in our means to make it great. This Federal Child Care Corporation bill is a great step in this direction. Let's inspire our youth and our nation.

The CHAIRMAN. Tomorrow we will have the Honorable Charles Goodell, the Honorable J. J. Pickle, and if he can make it, we will have the Honorable Marvin Mandel, who ran up a very impressive total in the Maryland primary on yesterday, and the Honorable Russell Arrington of Illinois, as well as the list of other witnesses that I will make available to the press.

The committee will now stand in recess until 10 o'clock tomorrow.

(Thereupon, at 12:55 p.m. the hearing recessed, to reconvene tomorrow, Thursday, September 17, 1970, at 10 a.m.)

THE SOCIAL SECURITY AMENDMENT OF 1970

THURSDAY, SEPTEMBER 17, 1970

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

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Talmadge, Byrd, Jr., of Virginia, Williams of Delaware, Bennett, Miller, and Jordan of Idaho.

The CHAIRMAN. We will commence these hearings this morning with the Honorable J. J. Pickle, Representative of the great State of Texas, and for a great congressional district. Representative Pickle

STATEMENT OF HON. J. J. PICKLE, U.S. REPRESENTATIVE FROM THE 10TH CONGRESSIONAL DISTRICT OF TEXAS

Mr. PICKLE. Mr. Chairman, thank you very much. I appreciate the chance to testify, and I want to thank you and Senator Anderson for the privilege.

Mr. Chairman, I am testifying here today because——

The CHAIRMAN. Might I ask you before you get started, Congressman Pickle, is my recollection correct that your district is the one in which our former President resides?

Mr. PICKLE. Yes, Senator. This is the 10th District of Texas, and when our beloved President was here I was referred to quite often as the President's Congressman. Of course, I always twisted it the other way and said he was my constituent, and he is my constituent now and I am very proud of it.

The CHAIRMAN. I want you to know that probably no one is more responsible for more amendments to the Social Security Act than your constituent, and it would have great weight with this committee, particularly on this side of the aisle, if you could assure us that what you are saying here this morning has the approval of your outstanding constituent.

Mr. PICKLE. Well, I must say that this has not been brought directly to his attention, but it will be, and it would be worth submitting.

The CHAIRMAN. Thank you.

Mr. PICKLE. Thank you, Senator.

Mr. Chairman, I am testifying here today because of deep concern over how section 225 of H.R. 17550 is going to affect the welfare programs of the States, the nursing home industry, and in particular the poverty-stricken patient who needs extended skilled nursing home, tubercular, or mental treatment. Section 225 seems to be at cross pur-

poses with the intent of the family assistance plan that this committee also has been holding hearings on. Here we are rewriting the welfare laws so that more of our citizens can enjoy the "good life," and at the same time under section 225 discriminating against a group that most certainly should receive assistance, the ill and the aged.

Section 225 of H.R. 17550 provides under the medicaid program that: (1) The Federal percentage after the first 90 days of care in a year in a skilled nursing home would be reduced by one-third; (2) the Federal percentage after the first 60 days of care in a general or TB hospital would be reduced by one-third; (3) the Federal matching funds for care in a mental hospital after 90 days of care would be reduced by one-third and no Federal matching would be available after an additional 275 days of such care during an individual's lifetime. To me, this seems an especially harsh treatment to mental patients who often need a lifetime of care.

Supporters of this section 225 in the House contended that the cut will save money for the States, as well as the Federal Government, by causing patients to be shifted to less expensive intermediate care facilities. However, attached is a letter from the Texas State Department of Public Welfare estimating that section 225 will cost Texas $68,020,940 annually. This estimate is based upon the assumption that the unemployed parent program of H.R. 16311 is enacted and these people become eligible for medicaid. Even if we disregard the effect of H.R. 16311, the Texas Welfare Department still estimates that section 225 will cost Texas $36,925,322 each year. I don't have figures to show how much this section 225 is going to cost other States, but from talking to some of my colleagues, I understand that many States are going to be in the same financial boat as Texas. Not only are we talking about a lot of money, but Texas will not have the time to raise the required funds before this bill will go into effect, January 1, 1971.

I cannot describe the financial condition of other State welfare boards, but the Texas budget is already operating in the red, some $26 million, and the board is having an extremely difficult time meeting the ever-increasing welfare rolls and the shift of many costs from the Federal to the State governments. Moreover, the effects this cut in funds would have on the nursing home industry are as yet largely unknown, but certainly adverse. Most important of all is the effect this section will have on those in need of skilled nursing, mental and tubercular care. The chief flaw of this section, I believe, is that it picks an arbitrary number of days after which a person supposedly no longer needs skilled nursing care or other types of treatment covered in section 225. Although it may be true that in some instances patients have been kept in skilled nursing homes when this special care was no longer necessary, and I think we will all admit that probably has ocurred, setting an arbitrary period of 90 days after which skilled care is not needed is not the answer to the problem. I am afraid that section 225 may cause a serious decline in skilled nursing homes.

Also, I have been told in a recent letter from Mr. Herbert Wilson, deputy commissioner of the Texas Welfare Department, that the department does not believe that at this time there are sufficient intermediate care facilities in Texas to take care of the shift in patients from skilled care to intermediate care facilities required under section

225. The question that haunts me is what happens to the patient who is shifted to an intermediate care facility after 90 days because of the cutback in funds under section 225, but still needs skilled care. What happens if there are not enough intermediate care facilities? I can't speak for all the States, but Texas does not have the money presently to pick up the extra cost, or a sufficient number of intermediate care centers. Many of the nursing homes are in such a financial bind that they can't afford to give the patient skilled care for intermediate rates. So what happens to this sick man? Do we put him out on the street? It looks to me like the Federal Government is defaulting on its responsibility.

I submit that section 225 should be amended or deleted. An arbitrary number of days is no way to judge what kind of care a patient needs. How can we tell a man that his health has to improve after 90 days or we will cut off the funds to provide care for him. As I have said earlier, I am all for eliminating any abuse that exists under the present law, but not at the expense of a patient who needs care and can't afford it.

In considering this problem, I think the committee would do well to study the second paragraph on page 190 of this committee's report number 744 on the 1967 Social Security Amendments. In that report there is language that says that it is the intention that skilled care under medicaid, title XIX is to be long term while skilled care under medicare, title XVIII is of a shorter term.

In addition to the attached letter from the department of welfare, I have received letters from the Texas Senate Interim Committee on Welfare Reform and the Texas United Community Services protesting section 225. I urge the committee to give serious consideration to changing or eliminating this language.

Mr. Chairman, I might add that when this bill was before the House, we did not have a chance to offer an amendment because it was submitted to us under a closed rule. Even so, the matter was put to a test on a previous question vote, and the House was so sensitive and so concerned about what would happen to the various States if this section 225 were put into effect, that the House came within some 15 or 20 votes of voting down the previous question in order that an amendment might be offered. I think that signifies the very great concern that that body has, and I hope that this body will either amend or delete it in some way to try to keep this language from going forward like it is now.

(Attachments to Congressman Pickle's statement and an additional statement of the Congressman, follow:)

STATE DEPARTMENT OF PUBLIC WELFARE,
Austin Tex., August 10, 1970.

Hon. J. J. PICKLE,
Congress of the United States, House of Representatives, Cannon House Office Building, Washington, D.C.

DEAR JAKE: Thanks for your letter of July 31, and for your continuous efforts regarding Section 225 of H. R. 17550.

You will recall that we had earlier estimated that the increase in federal participation included in Section 225 would save Texas $600,000 a year in state money, while the decreases in federal participation would increase medical costs to Texas by $68,620,940, for a net result of a cost to Texas of $68,020,940. This estimate was for 1972 and was based on the assumption that we would be required under H. R. 16311 to add the Unemployed Parent program in Texas.

However, assuming now that the state will not be required to add the Unemployed Parent program, our estimate of the net cost to Texas would be $36,925,322.

As you requested, I am enclosing some statistical material which shows the possible effect of Section 225 on Texas, in terms of additional state cost. The projected additional cost of $21,349,377 relates to care in nursing homes (extended care facilities, skilled nursing homes and intermediate care facilities) and for care in TB and MH/MR institutions. This table also includes our projections relating to intermediate care facilities because of that part of Section 225 which provides for a determination by the Secretary as to whether a reasonable cost differential exists between the cost of skilled nursing home services and the cost of ICF services. In his letter to you on June 2, 1970, Mr. Herbert C. Wilson, deputy commissioner, commented on this provision and offered our suggestion that state-owned facilities be excluded in this determination of reasonable cost differential.

The enclosed table does not include projections of the additional state costs for inpatient hospital services which would result from reduction of the federal percentage after 60 days of care. As you know, our costs in this area are related to premiums paid to our insurance carrier to cover hospital and physicians services, and we do not have full data on this immediately available to us. However, we believe that the additional state cost for inpatient hospital care, when added to the projected costs shown on the table, will approximate the net cost figure of $36 million previously provided you.

I hope this information will be helpful to you.

Sincerely yours,

BURTON G. HACKNEY.

Enclosure.

PROJECTED ADDITIONAL COST FOR STATE FISCAL YEAR—STATE FUNDS, SEPTEMBER 1971 TO AUGUST 1972

Type of care	Potential caseload [1] (universe) 1972	Percent in care from 1969 experience (percent)	Number in care	Days care above 90 days [2]	Number of patient-days	Daily rate	Total cost	State share at 33.34 percent	State share at 55.56 percent	Difference (additional State cost)
ECF [3]	286,818	0.285	817	35	28,595	$6.50	$185,868	$61,968	$103,268	$41,300
Skilled	325,820	2.882	9,390	203	1,906,170	12.00	22,874,040	7,626,205	12,708,817	5,082,612
MH [4]	286,818	.924	2,650	250	662,500	7.75	5,134,375	1,711,801	2,852,659	1,140,858
TB [5]	286,818	.057	163	139	22,657	20.59	466,508	155,534	259,192	103,658
Subtotal										6,368,428
ICF III [6]	325,820	6.535	21,292	209	4,450,028	10.00	44,500,280	14,836,393	24,724,356	9,887,963
ICF II	325,820	2.788	9,084	182	1,653,288	7.00	11,573,016	3,858,444	6,429,968	2,571,524
MR [7]	822,466	.655	5,387	275	1,481,425	7.66	11,347,716	3,783,329	6,304,791	2,521,462
Subtotal										14,980,949
Total										21,349,377

[1] Potential caseload of 286,818 includes adults 65 years old or older. Potential caseload of 325,820 includes adults over 21 years. Potential caseload of 822,466 includes all recipients, in all three adult categories plus AFDC.
[2] For TB, days care above 60 days.
[3] Extended care facility.
[4] Mental health.
[5] Tuberculosis.
[6] Intermediate care facility.
[7] Mental retardation.

STATEMENT OF HON. J. J. PICKLE, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS, SEPTEMBER 23, 1970

Mr. PICKLE. Mr. Chairman, I am pleased to have the honor today to present to this Committee, two amendments to H.R. 17550, the pending Social Security legislation. I spoke to you recently regarding another matter in this legislation— the provisions which deal with our nursing homes, and I thank the Committee for their careful consideration of my remarks at that time.

Today I would like to discuss two amendments which have been offered by my fellow Texans, the Honorable Senator Yarborough and the Honorable Senator Tower. These amendments both address the problem that many of our smaller rural hospitals are encountering in providing twenty-four hour RN coverage. The Social Security Act states that the hospital will qualify for Medicare certification only if it provides "24-hour nursing service, rendered or supervised by a registered professional nurse on duty at all times." (Section 1861(e)(5)). The Social Security Administration, however, has generally interpreted this section to mean that all hospitals must have 24-hour coverage by registered nurses in order to qualify for certification.

I fully realize that this requirement, where it can be met, is of benefit to the patients in the hospitals and to our national health service as a whole. If it would be posible to find the manpower, I think we would all agree that it would be a good thing to go further than present law and to have an accredited medical doctor on duty at all times.

The problem is the shortage of manpower in our health services. Particularly hard hit in this shortage are the small rural hospitals. Try as they might, many of these hospitals simply cannot get enough RN's to provide 24-hour coverage.

Until such time as this nation is blessed with sufficient health service manpower to offer our citizens what we might call the highest ideal in quality of service, the question remains, what shall we do with these small hospitals. Shall we keep them open and offer the best services that are possible, or shall we shut them down and deny many of our rural citizens any local hospital service at all? The question is almost one of keeping them open or shutting them down, because without Medicare certification, many of these small hospitals cannot make a go of it financially.

I don't think I need to point out to the members of this Committee the hardships that would be incurred by our rural citizens and their families if every time they had a baby, or broke a leg, or required the services of a hospital for some other reason, they had to rely on a distant hospital in a major city. Nor do I think I need to point out that many lives are saved by the prompt emergency treatment administered to accident victims or victims of acute illnesses. Since in these cases time is of the essence, many of our rural citizens would in reality have the quality of medical service available to them substantially reduced if they had to rely on a major hospital forty or fifty miles away, or more, rather than having emergency facilities available a few miles away.

Both of the Senators from Texas, recognizing the dangers and the needs in this situation, have introduced amendments to the Social Security legislation pending before your Committee, which hope to clarify the law on this matter and to provide for the best health service that can in reality be offered to the citizens of this nation. Today, Senator Yarborough introduced an amendment which gives the Secretary of HEW the power to give a year-by-year exemption from the 24-hour RN requirement if the hospital in question can satisfactorily prove that it has been trying its best to recruit the necessary number of RN's, but simply cannot do so. Last week Senator Tower introduced an amendment which exempts hospitals of 50 beds or less from the RN requirement.

Both of these amendments are compatible in thought, and both provide realistic approaches to the problem. I would support either of these Senate amendments as viable solutions to the problem of providing the best medical services possible. Legislation comparable to the Senate amendments has been introduced in the House as independent bills. I have introduced a bill that is comparable to Senator Yarborough's amendment and my friend and colleague, Congressman Burleson, has introduced legislation comparable to Senator Tower's amendment. Although legislative remedies have been introduced so far only by Texans, this problem is not limited to the confines of any one state. We have just been the signalmen for a crisis spreading across the nation.

Senator ANDERSON (presiding). Senator Byrd, any questions?
Senator BYRD. No questions, Mr. Chairman.
Senator ANDERSON. Senator Jordan.
Senator JORDAN. Congressman, I share your concern. This section 225, I agree with you, should either be amended or deleted because I have the same apprehensions about it as you do, and you have expressed it here very well. Thank you.
Mr. PICKLE. Thank you, Senator.
I am mindful, that as Members of Congress, of both the House and Senate, we must make whatever effort we can to cut down the costs, both Federal and State, but if we can work a better answer, fine, but to do it on a 90-day basis and not give the States time to deal with the situation will play havoc with most of the States.
Senator ANDERSON. Thank you, Congressman.
Mr. PICKLE. Thank you, Senator, very much. I appreciate the courtesy extended to me this morning.
Senator ANDERSON. Mr. Arrington.

STATEMENT OF STATE SENATOR W. RUSSELL ARRINGTON, PRESIDENT PRO TEMPORE AND MAJORITY LEADER, ILLINOIS STATE SENATE; ACCOMPANIED BY JOHN BRIGGS, DEPUTY DIRECTOR, MENTAL HEALTH DEPARTMENT, STATE OF ILLINOIS

Mr. ARRINGTON. Good morning, gentlemen.
I have with me here Mr. John Briggs, who is the deputy director of our Mental Health Department in Illinois.
I have a more complete statement than I will make here. I am speaking from the statement here in abbreviated form, and I should like to request that I may submit the more complete statement.
I want to thank you also for the courtesies you have previously extended to me on other issues, particularly the one relating to private foundations in which you were kind enough to accept the suggested change that I made, and I was quite happy about it. I always appreciate the opportunity to testify before your committee, and today, in connection with the amendments to title XIX.
With the enactment in 1965 of titles XVII and XIX to the Federal Social Security Act, the National Government entered into what was anticipated to be an effective partnership with the States.
Senator ANDERSON. Just one second here. Senator Percy, did you wish to introduce Mr. Arrington?
Senator PERCY. Mr. Chairman, I am sorry for the brief interruption, but I was just on the floor, and I heard that the president pro tempore of our senate was appearing before you, and I wondered if he would mind my taking 30 seconds to just introduce him officially.
Mr. ARRINGTON. I would be delighted, though, if you would not mention the fact that I passed the income tax in Illinois. [Laughter.]
Senator PERCY. We won't do that. I just made out my check yesterday.
I understood there was to be one witness, Governor Mandel, ahead of you, and I was just notified that you were going first.
Mr. Chairman, and members of the committee, just yesterday I had an opportunity to appear before you and testify on behalf of my proposals to improve the social security program.

I suppose I have testified over a period of 15 or 20 years more times before this committee than any committee certainly in the House or Senate. But it is with great pleasure that I introduce a very distinguished witness, a fine friend of mine, my own senator from the North Shore of Chicago, and preseident pro tempore of the senate, Russell Arrington.

He is the majority leader and president pro tempore of the Illinois Senate. He is also one of three State legislators to the Advisory Commission on Intergovernmental Relations, and a director of the Alberto Culver Co.

He is one of our most prominent and noted attorneys and, personally, I have been more grateful to him for the devotion that he has had to State government than anyone in our State. He has not only done a great deal to strengthen the Federal system by strengthening State government, but he has been a right arm of our Governor in putting through, as he mentioned, very unpopular issues, but in order to be utterly responsible and have State government responsive to the needs of the people so we do not always depend on the Federal Government.

He is a man of great compassion, great understanding, but also a very hard head. He is practical, realistic, and a great leader of our senate.

It is with a great deal of pleasure that I introduce him. I feel that the position he has taken which, I understand, is consistent with the position taken by Governor Ogilvie, differs from others. But I think his point of view will be extremely important to the members of this committee.

I am honored, indeed, Senator Arrington, to introduce you to this committee and to the four members who are here today who are fine friends that I have in the Senate who have worked long and hard to find the right answer to this problem of welfare, and I think they will be most interested in what you have to say.

Mr. ARRINGTON. Thank you very much.

Senator PERCY. Thank you, Mr. Chairman; very much indeed.

Senator ANDERSON. Go right ahead.

Mr. ARRINGTON. With the enactment in 1965 of titles XVIII and XIX to the Federal Social Security Act, the National Government entered into what was anticipated to be an effective partnership with the States.

The inescapable fact remains, however, that we, the Federal Government and the States, have failed, and failed substantially, not only to meet the health care needs of the less affluent people in our communities, but also to design anything that could be confidently looked upon as an efficient or an effective way of providing such services.

In all events, I think H.R. 17550 can be nothing more than a transitional action. It cannot be permanent, I think because as you know, the assurance of the administration has made that they are going to have ready for introduction in January a proposed family health insurance plan. You have already before you the family assistance plan, and if those become effective, and we all hope they will, this action can in any event, be nothing but a transitory, nonpermanent action.

It is impossible in the context of H.R. 17550, and in the time that is available, to do more than, in my opinion, two things: (1) express

our mutual concerns as to our inadequacies in dealing with health care problems; and (2) make such adjustments as will tend to restrict further abuses and distortions in the current system while directing our major efforts at a new system that is responsive and responsible in terms of real needs.

To indulge in extensive patch working around present inadequacies will invite greater difficulties in the ultimate solution to our problem.

Any appropirate modification of the existing programs should be pursued only in reference to our ultimate objective. That ultimate objective in a continuing partnership between the National and State Governments to provide comprehensive health care services dictated by the needs of individuals for those services and by our ability to provide those services.

In pursuing the objective of comprehensive health care on a real partnership basis, it is essential that there be an end to any and all discrimination with respect to the site where service is delivered. Further, we must emphasize the delivery of services to individuals in response to real needs. The arbitrary distinction between services provided in State operated facilities, is discrimination of the worst kind.

The objective of returning as many individuals as possible to positions of social and economic independence so that they might become productive members of our society, rather than drains upon our resources, has been actively pursued by the States.

In Illinois, for example, we have moved in a very short period of time from State institutions with populations totaling approximately 38,000 5 years ago to a population of less than 25,000 at the present time and this trend is national.

This has been possible because we have emphasized the provision of treatment rather than the warehousing of people and the provision of minimal care.

The significance of calling these facts to your attention is twofold: (1) To indicate that the States have taken a leadership role in providing for human needs and providing for those needs in a treatment oriented direction that restores individual productive capabilities; (2) The enactment of H.R. 17550 will, unless its provisions are changed, return this nation to a situation where its State-operated institutions will experience an increase in the number of people for whom treatment will be required.

Under the provisions of H.R. 17550, the inevitable result will be a decline not only in treatment but also care.

We all know the record of our State institutions when their patient populations become large. We will be going backward to a condition which we have long sought to correct. The Federal Government cannot abdicate its responsibility by simply saying, "Let the States pick up the costs to avoid this inevitable result."

Why do we not deal directly with part of the problem—mental retardation—by eliminating the prohibition in the Social Security Act that says—for apparently fiscal reasons only—that the categorical program for aid to the totally and permanently disabled shall exclude the mentally retarded?

H.R. 17550 proposes that those individuals in State facilities that are in need of care and treatment beyond the period of 365 days in

their lifetime be denied care and treatment, unless that responsibility is taken over totally by the States.

There is no logic to saying that a person who is ill or in need of care for a period in excess of 365 days during his lifetime should be relegated to an institutional warehouse, while the next person who, because his care needs require less treatment, shall be treated and shall be treated adequately.

Perhaps the greatest contradiction in all of the considerations of this issue is the fact that we are trying to achieve a dollar expenditure reduction and at the same time, create the image that we are doing so because of a primary consideration for health care. But recovering from that position to one where we are responsible and effective is not going to be achieved by indulging in fiscal maneuvering. It will be achieved only by the head-on realization that we must do something and do it constructively. The bill, as it currently stands, does not move us in the right direction. On the contrary, it moves us in exactly the wrong direction.

The suggested implication of the implementation of H.R. 17550 is not speculative. Let me tell you what is happening in the State of Missouri. The State of Missouri has a fiscal problem, which to my knowledge every State as well as the Federal Government has. Missouri chose—in their public welfare program—to restrict the level of reimbursement for care in private nursing homes. In addition, it reclassified—as to level of care required—certain individuals in private care facilities. This meant that the private care industry was faced with a reduction in the level of payment by the State for persons without resources other than those available through the State and the companion medicaid program. The private operators are taking the position that, faced with increasing operating costs, they will be unable to provide care and treatment for these people. They have already begun to return these people to the State institutions. We have begun the regressive road back to where we were 5, 10, 15 years ago rather than where we ought to be or want to be.

The reality of the problem which the Federal Government faces, mainly the costs involved in providing adequate care through a system which is inadequate and unresponsive, is recognized by all of us.

Consequently and on the positive side, many States, including Illinois, have to the extent that they have been able been moving toward improvement. For example, in the State of Illinois, we now have a formal policy with respect to providing services to persons in need of treatment and care in all facilities in the State.

As another example, our licensing standards have been totally revised (upward) and the emphasis has been placed not on custodial care but on treatment programs that are designed to meet the treatment needs of the individuals. In addition, we are moving away from the estimating of costs by the use of averages with all the implications that this has with respect to empty beds, overhead, and other such factors being inappropriately charged to either the State or Federal Government.

There are a variety of things we are going to do in that connection, Mr. Chairman. I would like the consent of the committee to file with your clerk, with your secretary, some documents that we have which symbolize the rather marked actions that we have taken in our State.

Getting down to the alternatives that you gentlemen face and have, I think, and to be consistent, compatible, with the cooperative approach with the States, the continuing partnership for providing health care where needed, I would like to make the following four suggestions in an effort to suggest the alternatives that you might have in the decision of the present bill.

1. We believe that the statutory authorization should be provided to States to determine, predetermine, allowable hospital rates for reimbursement under medicaid. The proposed amendment to section 1902(a) included in H.R. 17550 is a positive step forward, but it does not go far enough if we are to get a handle on medical costs related to services provided. It is our recommendation that this provision be extended to include rates for outpatient care. Otherwise, this provision could become an incentive encouraging a renewed reliance on expensive, institutionalized hospital care.

2. We suggest that there be continued the present level of financial assistance to the States in terms of dollars plus an increment for cost increases for a period of 1 year. In other words, to freeze the present level of distribution, make an allowance for the necessary increment for cost increases. During that time we can all pursue the development of an adequate health care delivery system for our less affluent citizens centered around the administration's proposal that we expect and you expect, I believe, to have before you in January.

3. Provide that the mentally retarded in all categories, but most assuredly in the severally and profoundly retarded category, be made eligible for assistance under the categorical grant program of aid to the totally and permanently disabled.

4. Make all Federal grants in terms of the levels of cost subject to approval by the Secretary of HEW, who should be authorized and encouraged to strengthen all auditing procedures. In terms of need and effectiveness, however, this should be based on the right to recover payments made to any provider, after the fact, so as not to deter the delivery of services.

I wish to thank you very much for the opportunity to appear before you and for the attention you have extended me.

(The prepared statement of Mr. Arrington follows. Hearing continues on page 671.)

TESTIMONY OF STATE SENATOR W. RUSSELL ARRINGTON, PRESIDENT PRO TEMPORE AND MAJORITY LEADER, ILLINOIS STATE SENATE, SEPTEMBER 17, 1970

Mr. Chairman, members of the Senate Finance Committee, I appreciate the opportunity to testify in behalf of the National Legislative Conference regarding amendments to Title XIX of the Social Security Act which we find in H.R. 17550, under consideration today.

With the enactment in 1965 of Titles XVIII and XIX to the Federal Social Security Act, the national government entered into what was anticipated to be an effective partnership with the States. This partnership was intended to achieve an effective approach toward inducing the existing health care delivery service systems of this country to provide adequate and needed services to the less affluent with a reasonable allocation of total resources to this objective. I believe the Federal government, as I know the State of Illinois and I believe all other states, has pursued this partnership with good intent. The inescapable fact remains, however, that we, the Federal government and the states, have failed and failed substantially not only to meet the health care needs of the less affluent people in our communities, but also to design anything that could be confidently looked upon as an efficient or an effective way of providing such services. This conclusion is highlighted by this Committee's hearings on the proposed amendments to the Social Security Act incorporated in H.R. 17550. Further evidence of

this unsuccessful experiment is available in the proposed redirections outlined by the Family Assistance Plan and the proposed Family Health Insurance Program which it is expected will be presented to the Congress by the Administration in January of 1971. Because these two measures will soon be before you, constructive progress can be made now if we would first recognize that amendments to the present programs for providing medical assistance must necessarily be transitional and not permanent. It is impossible in the context of H.R. 17550 and the time that is available to do more than:

1. Express our mutual concerns as to our inadequacies in dealing with health care problems; and
2. Make such adjustments as will tend to restrict further abuses and distortions in the current system while directing our major efforts at a new system that is responsive and responsible in terms of real needs.

To indulge in extensive patch working around present inadequacies will invite greater difficulties in the ultimate solution to our problem.

Any appropriate modification of the existing programs should be pursued only in reference to our ultimate objective. That ultimate objective is a continuing partnership between the national and state governments to provide comprehensive health care services dictated by the needs of individuals for those services and by our ability to provide those services.

The problem of need identification is obviously a difficult one, one which will realistically never be solved except by practical experience and continuous review and, where necessary, adjustment. We obviously must come to grips with the problem of what level of care will identify as a public responsibility. The hard decision must ultimately be made whether the investment of resources justifies the returns.

We must also recognize that the existence of adequate health care delivery systems, while a responsibility of national and state governments, must also include, as equally active partners, individual citizens. Governmental participation relates primarily to those citizens who themselves are unable to provide all the necessary health care services that constitute a reasonable level of care and treatment which is determined to be appropriate as a matter of public policy. Much of the expense and the rising cost of health care services in this country are due to our failure to deal with comprehensive health care as opposed to certain aspects of health care each of which has its own vocal lobbyists and seeks to elevate its individual position in terms of both power and income.

In pursuing the objective of comprehensive health care on a real partnership basis, it is essential that there be an end to any and all discrimination with respect to the site where service is delivered. Further, we must emphasize the delivery of services to individuals in response to real needs. The arbitrary distinction between services provided in state operated facilities, for example, contrasted with those provided in privately operated facilities, is discrimination of the worst kind. It can find its justification only in terms of a national policy effort to shift the cost of service from a total partnership basis to the state governments. This kind of continuous discrimination, some of which is again repeated in H.R. 17550, makes progressively more difficult the development of a real partnership between the Federal and state governments.

The willingness of state government, certainly ours in Illinois, to cooperate is well demonstrated. The objective of returning as many individuals as possible to positions of social and economic independence so that they might become productive members of our society, rather than drains upon our resources, has been actively pursued by the states. The states have embarked upon substantial commitments in programs of treatment of the medical, mental and social problems that have tended to restrict the ability of individuals to function effectively. We have moved in a very short period of time, for example, from state institutions with populations totalling approximately 38,000 in Illinois five years ago to a population of less than 25,000 at the present time. This trend is national.

This has been possible because we have emphasized the provision of treatment rather than the warehousing of people and the provision of minimal care. That this record is restricted to the lower and middle aged groups is not supported by fact. In 1965 in Illinois there were approximately 10,000 persons 65 years and over in our state institutions. Currently, that number is approximately 7,000 and declining constantly. The significance in calling these facts to your attention is twofold:

1. To indicate that the states have taken a leadership role in providing for human needs and providing for those needs in a treatment oriented direction that restores individual productive capabilities;

2. The enactment of H.R. 17550 will, unless its provisions are changed, return this nation to a situation where its state operated institutions will experience an increase in the number of people for whom treatment will be required.

Under the provisions of H.R. 17550, the inevitable result will be a decline not only in treatment but also care.

H.R. 17550 seeks to solve a fiscal problem by way of restricting services to individuals. For instance, it is proposed that the cost abuses that are indulged in by our private hospitals and other private care facilities be solved at the expense of the persons receiving service. The proposal is to reduce the level of financial assistance for those persons who cannot pay for their own care. The provider's response will be to cease providing service to that clientele group. Realistically, this will not hurt the private care institutions. It will hurt only the people that need the services the most and are least able to provide for them. In the absence of adequate services or even space in the private care institutions, the individuals affected will of necessity find their way back to the state institutions.

We all know the record of our state institutions when their patient populations become large. We will be going backward to a condition which we have long sought to correct. The Federal government cannot abdicate its responsibility by simply saying, "Let the states pick up the costs to avoid this inevitable result."

Why do we not deal directly with part of the problem (mental retardation) by eliminating the prohibition in the Social Security Act that says (for apparently fiscal reason only) that the categorical program for aid to the totally and permanently disabled shall exclude the mentally retarded?

H.R. 17550 proposes that those individuals in state facilities that are in need of care and treatment beyond the period of 365 days in their lifetime be denied care and treatment, unless that responsibility is taken over totally by the states. Here again, let me impress upon you that it is impossible for this country to fulfill its responsibilities of providing health care to its citizens in need if we attempt to parcel out the clientele among the Federal government, the states, the health care institutions in the private sector or the professional groups that are involved in the treatment of people for all health needs. If ours is to be a meaningful program, it must be one that in fact represents total cooperation and joint participation. There is no logic to saying that a person who is ill or in need of care for a period in excess of 365 days during his lifetime should be relegated to an institutional warehouse, while the next person who, because his care needs require less treatment, shall be treated and shall be treated adequately.

Perhaps the greatest contradiction in all of the considerations of this issue is the fact that we are trying to achieve a dollar expenditure reduction and at the same time, create the image that we are doing so because of a primary consideration for health care. Admittedly we are in a situation where this nation's collective health care delivery system is expensive and ineffective. But recovering from that position to one where we are responsible and effective is not going to be achieved by indulging in fiscal maneuvering. It will be achieved only by the head-on realization that we must do something and do it constructively. H.R. 17550 as it currently stands does not move us in the right direction—rather it moves in exactly the wrong direction.

The suggested implication of the implementation of H.R. 17550 is not speculative. Let me tell you what is happening in the State of Missouri. The State of Missouri has a fiscal problem, which to my knowledge every state as well as the Federal government has. Missouri chose (in their public welfare program) to restrict the level or reimbursement for care in private nursing homes. In addition, it reclassified (as to level of care required) certain individuals in private care facilities. This meant that the private care industry was faced with a reduction in the level of payment by the state for persons without resources other than those available through the state and the companion Medicaid program. The private operators are taking the position that, faced with increasing operating costs, they will be unable to provide care and treatment for these people. They have already begun to return these people to the state institutions. We have begun the regressive road *back* to where we were five, ten, fifteen years ago rather than where we ought to be or want to be.

The reality of the problem which the Federal government faces, mainly the costs involved in providing adequate care through a system which is inadequate and unresponsive, is recognized by all of us.

Consequently and on the positive side, many states, including Illinois, have to the extent that they have been able been moving toward improvement. For

example, in the State of Illinois, we now have a formal policy with respect to providing services to persons in need of treatment and care in all facilities in the state. For instance, by classification, from skilled nursing homes all the way down to a room and board sheltered care facility, all facilities must be licensed or licensable before they are eligible to receive persons placed by our state hospital system or before they are eligible to receive financial assistance through any public welfare programs. As another example, our licensing standards have been totally revised (upward) and the emphasis has been placed not on custodial care but on treatment programs that are designed to meet the treatment needs of the individuals. In addition, we are moving away from the estimating of costs by the use of averages with all the implications that this has with respect to empty beds, overhead, and other such factors being inappropriately charged to either the state or Federal governments.

We are also continuing to move in the direction of outpatient services, and we applaud the Federal government's recognition of the value of this and their corresponding proposals incorporated in H.R. 17550 to expand Federal financial participation in this area. This is a step in the right direction and we in Illinois are taking steps now to see to it that this program does not become restricted two or three years from now by many of the problems that are currently encumbering the Medicaid and Medicare programs.

Supplementing my statement I should like to file with your Committee copies of our licensing provisions and a statement of our state policy with regard to placement and care in privately operated facilities. Also I should like to leave with you recommendations relating to Controlling Health Care Costs in Illinois, which are being implemented in our state now.

We have gone a further step toward developing a flexible payment schedule. We have constructed and are using a point system in order to establish payment differentials, based on the level of care and treatment provided by private care operators, in determining the level of state financial participation in their programs.

We have also just inaugurated a new program aimed at continuous evaluation of the services provided by all aftercare providers to assure a quality of care that is consistent not only with the level of financial support but also with the needs of the persons served.

My point, gentlemen, in using these illustrations is to indicate to you tangibly that the states are not sitting idly by, attempting to take advantage of the Federal government. If the Federal government has serious cost problems, you can be assured that every state in this union has the same kinds of problems and in relatively greater magnitude.

What kind of an alternative is available to the Federal government that will be consistent and compatible with a cooperative approach with states and adequate programs for providing health care where needed? There are obviously many alternatives, many of which have considerable merit. May I offer the following for your consideration:

1. Provide statutory authorization to states to predetermine allowable hospital rates for reimbursement under Medicaid. The proposed amendment to Section 1902(a) included in H.R. 17550 is a positive step forward, but it doesn't go far enough if we are to get a handle on medical costs related to services provided. It is our recommendation that this provision be extended to include rates for outpatient care. Otherwise, this provision could become an incentive encouraging a renewed reliance on expensive, institutionalized hospital care.

2. Continue the present level of financial assistance to the states in terms of dollars plus an increment for cost increases for a period of one year. During that time we can then all pursue the development of an adequate health care delivery system for our less affluent citizens centered around the Administration's proposal that we expect to be before Congress in January of 1971.

3. Provide that the mentally retarded in all categories, but most assuredly in the severely and profoundly retarded category, be made eligible for assistance under the categorical grant program of aid to the totally and permanently disabled.

4. Make all Federal grants in terms of the levels of cost subject to approval by the Secretary of HEW, who should be authorized and encouraged to strengthen

all auditing procedures. In terms of need and effectiveness, however, this should be based on the right to recover payments made to any provider, after the fact, so as not to deter the delivery of services.

The effect of this program would be to display a total commitment and an appropriate one, to move forward over the next year in the design, development and implementation of an effective program that is responsive to the health care needs of the less affluent. It would represent a program displaying Federal government leadership and state government cooperation and support in a balanced program aimed at results. It would constitute a program which a year and a half from now will not be an embarrassment to the Congress, to any state government official, or to any citizen. This program, totally and effectively communicated, will provide a sobering influence upon all those who may hope that there will be no limit to spiralling costs, many of which are unnecessary.

The time and effort of this Committee and staff and all of those who have cooperated directly and indirectly with you on this particular issue, have been dealing with what ought to be recognized as a stop-gap measure that solves nothing and has the potential of hurting many. I recommend the above program to you with the objective of stabilizing the current situation, tangibly indicating good faith in a continuing copartnership between Federal and state governments. It provides a positive direction during a reasonable period of transition until we can finally have an effective or at least a more effective program that is output oriented to meet the needs of the people who have real needs for health care services.

If the Congress of the United States, through this Committee, can tangibly indicate its desires to move in this direction, I am confident that I speak for all of the states, and certainly for the State of Illinois, for both its executive and legislative branches, in saying that there will be total cooperation and that there will be total support for a realistic program.

Senator ANDERSON. You have been a fine witness, and we appreciate it very much.

Mr. ARRINGTON. Thank you, sir.

The CHAIRMAN (presiding). Thank you very much, sir.

Might I suggest that before we proceed further we hear a brief statement from Senator Byrd. He may find it necessary to depart to take care of other matters.

Mr. ARRINGTON. You are through with me, Mr. Chairman, are you?

The CHAIRMAN. Yes, sir. Thank you.

I would like to note the fact that we have, you might say, an upgrading of the quality of our staff this morning. I notice a lady from Virginia who once lived about a block down the street from me in New Orleans, sitting among our staff this morning, and I think our staff has probably gained charm and beauty that it has not had for a long time. I wish to welcome our former neighbor to a place among our staff this morning.

The Senator from Virginia.

Senator BYRD. I thank the chairman, and I would say that I agree thoroughly with his observations.

Mr. Chairman, I would like to make a brief statement in connection with some information I have tried to obtain on the cost of the administration's welfare proposal. Material prepared by the committee staff showed that the Department of Health, Education, and Welfare had estimated a cost of $8.2 billion in fiscal year 1971 for the House-passed bill compared with an estimated cost of $9.1 billion under the adminis-

tration revision. I assumed that the $900 million increase in cost related to the many amendments to the bill recommended by the administration. The committee will recall that on July 23—and I cite that date again: July 23—I asked Secretary Richardson for a reconciliation of the cost estimate presented to the House and the new one presented to the committee. Secretary Richardson did not have the answer, but he agreed to supply it to me.

I had not received an answer by the next week. On July 29, I again asked the Secretary for the reconciliation and received a reply to my letter on August 1, but instead of reconciling the estimate associated with the House bill with the estimated cost of the revised administration bill, the material submitted by the Department merely placed the two cost estimates side by side.

I wrote the Secretary on August 12 stating that the reconciliation I had in mind would show the cost of each of the significant amendments to the bill requested by the administration. I sent the Secretary a form with each major amendment listed, and asked him to have the blanks filled in. I have not yet received the material I requested. Now, that was on August 12, Mr. Chairman.

It seems to me, Mr. Chairman, that before the committee can intelligently and responsibly consider the many amendments recommended by the administration, we should have some idea of their cost. It is my hope that the Department of Health, Education, and Welfare will not delay our consideration of the bill by failing to provide us with the hard data we need to make intelligent decisions, and responsible decisions.

I want the record to show that the committee has sought facts and information from the Department which has not yet been supplied.

Mr. Chairman, I ask unanimous consent that there appear at this point in the record excerpts of the hearings on the welfare bill as well as a copy of the letter I sent to Secretary Richardson on August 12.

The CHAIRMAN. Of course that is agreed to.

(The documents referred to follow. Hearing continues on page 677.)

EXCERPTS FROM HEARINGS ON ADMINISTRATION WELFARE BILL

1. JULY 23, 1970

Senator BYRD. Mr. Chairman, may I ask three brief questions?

Mr. Secretary, the fiscal year 1970 ended last month. What was the cost of the welfare program, the Federal cost, for that fiscal year which ended June 30?

Secretary RICHARDSON. The figure is somewhere around 4½ billion dollars. We could correct it.

Senator BYRD. That is close enough. I had $4.4 billion, so that is close enough.

The next question is this: You estimate the cost of fiscal year 1971 at $9.1 billion. That is on page 23 of the committee print.

Secretary RICHARDSON. The costs there, Senator, include some things that are not covered in the $4.4 billion.

Senator BYRD. I understand. But what I have is the total cost of $9.1 billion is estimated for 1971.

Secretary RICHARDSON. Yes.

Senator BYRD. Do you have an estimate for 1972, because this program will not go into effect until 1972?

Mr. VENEMAN. The next chart, I think, may have that.

Secretary RICHARDSON. The total cost is shown on the chart on page 24 of the committee print as $8 billion. That covers payments to families and it also covers the Federal share of the adult categories.

The difference in the figure from the $9.1 billion you used earlier is that the $8 billion covers only assistance payments. It does not cover training programs and it does not cover food stamps.

Senator BYRD. What I am trying to do is to get a figure that would be the total cost of the welfare program for the fiscal year 1972.

Secretary RICHARDSON. The way these figures have been combined, I do not have readily at hand a comparable figure to the $9.1 billion; in other words, a figure which covers not only payments to families but food stamps, costs of training, day care, and so on.

Senator BYRD. Everything.

Secretary RICHARDSON. So we will have to supply this. It would certainly be on a full-year basis somewhat higher than $9 billion.

Senator BYRD. Well, would you supply that for the record, and would you send a copy to my office, also?

Secretary RICHARDSON. I would be glad to.

Mr. VENEMAN. Did you want medicaid included in that, Senator?

Senator BYRD. Yes.

Mr. VENEMAN. Medicaid as well.

Senator BYRD. That is part of your new program.

Mr. VENEMAN. Well, no. These projections would be based upon the existing program, the current program. Now we have not projected the new insurance concept, but——

Senator BYRD. Make it on your existing program and that would make the figure comparable.

Mr. VENEMAN. No, because medicaid is not included in the one you just gave, the $9.1 billion, which includes payments to families, direct grant payments, plus administration, plus services.

Senator BYRD. Plus food stamps.

Mr. VENEMAN. No, that is not in the——

Senator BYRD. That is in the $9.1 billion.

Mr. VENEMAN. That is in the cost of administration—$0.4 billion is the figure, is it not?

Senator BYRD. Right.

Mr. VENEMAN. That is food stamps and administration.

Senator BYRD. Is not the increased cost of medicaid in the item listed "Other increased costs," $0.9 billion? What I am trying to do is to get a figure comparable to your $9.1 billion figure.

Mr. VENEMAN. For 1972, we will submit that.

Secretary RICHARDSON. We will have to supply that, because the figures we have readily at hand are not broken out in quite that way.

Senator BYRD. Would you also supply for the record a reconciliation of the past and present cost estimates?

Secretary RICHARDSON. Yes. I would also, in that connection, Senator, undertake to supply for the record an analysis of the $900 million differential between earlier and later estimates insofar as this reflects changes in the scope of the food stamp plan and increased estimates under current AFDC and adult category coverage.

2. JULY 29, 1970

Senator BYRD. Thank you, Mr. Chairman.

Mr. Secretary, I would like to go back to where we left off last week. You were to get for the committee the estimate of the total costs of the welfare program for the fiscal year 1972, assuming that your program is enacted into law.

Secretary RICHARDSON. Yes. What was the question, Senator? I am sorry.

Senator BYRD. Well, the question is, assuming your program is enacted into law by the present Congress, what will be the total cost of the welfare program, the Federal share, for fiscal year 1972?

Secretary RICHARDSON. About $8 billion.

Senator BYRD. I find that difficult to reconcile with the fact that you state that for fiscal year 1971, if this program were enacted, would be $9.1 billion, and then you said in your testimony last Thursday that it would be on a full-year basis in 1972, it would be somewhat higher than $9 billion.

Secretary RICHARDSON. Well, Senator, I am sorry we certainly do seem to be back where we left off.

The figure I gave you of $8 billion is the figure of the Federal cost of the maintenance payments under the family assistance plan, and it is not comparable with the $9.1 billion which includes the costs of the training and the day care and food stamps, and so on.

Senator BYRD. That is quite right. That is what we want to get.

Secretary RICHARDSON. The costs, if you include these other factors, would be roughly $10 billion to $10½ billion, depending upon what the President and the Congress elected to do in providing for levels of training and day care.

Senator BYRD. So for fiscal year 1972, if your program is enacted, you estimate that the costs will be between $10 billion and $10.5 billion?

Secretary RICHARDSON. Yes; depending, as I said, on day care and other factors. It could be held down through. The increase in the costs of maintenance we project is about $200 million. If you allowed an increase of, say, $200 million in food stamps, then you would have a question of judgment of how much more to put into day care and training. If these were not substantially increased over the figures shown for 1971, it would, of course, correspondingly hold down the aggregate increase.

Senator BYRD. In any case, it would be a minimum of $10 billion, it would run somewhere between $10 billion and $10.5 billion as a minimum; is that correct?

Secretary RICHARDSON. Well, I would not say as a minimum. That is an estimate. It could be less, as a minimum, if the training and day care figures were held to the 1971 level.

Senator BYRD. It could be more, I assume, too. It could be more.

Secretary RICHARDSON. I think it would be very unlikely to be more, Senator.

Senator BYRD. Then that figure of $10 billion to $10.5 billion would correspond, I assume, with the figures on page 23 of the committee print which add up to $9.1 billion.

Secretary RICHARDSON. What was the question, Senator?

Senator BYRD. I assume that the figure of $10 billion to $10.5 billion corresponds to the $9.1 billion figure on page 23 of this blue book of the committee?

Secretary RICHARDSON. Yes. I meant it to be a corresponding figure. It may be high, Senator, if we were simply to go forward with a figure for 1972 that reflected only the mandatory increases. Due to projected increases in numbers of families, and so on, the comparable figure would be $9.3 billion, assuming that the day care, training, and food stamps were held level.

Senator BYRD. You will make up the fiscal 1972 budget, will you not, and I assume you are beginning to work on it pretty soon?

Secretary RICHARDSON. Yes; we are. But, of course, the program has not been enacted. Under current law the anticipated Federal share of the maintenance payments is about $5.6 billion. That may be a little low under current estimates.

Senator BYRD. You were going to give us a breakdown of the item listed "Other increased costs" of $0.9 billion—$900 million. What is the breakdown of that figure?

Secretary RICHARDSON. That is in three components—$300 million of it is for projected increases in AFDC costs under current law; $200 million is for projected increases in adult categories under current law; and $400 million is the anticipated increase in cost of food stamps due to the automatic checkoff.

Senator BYRD. Well, now, you have got increased costs of food stamps of $400 million in another category.

Secretary RICHARDSON. I am not sure what you mean by "another category," Senator. It is part of the $900 million.

Senator BYRD. Would you mind giving us a breakdown again of that $900 million?

Secretary RICHARDSON. $500 million is the cost of coverage of existing categories under current welfare law; $400 million is the cost of food stamps. We have a tabulation for the committee which was to be inserted in the record earlier, and I will see that you get this this afternoon, Senator.

Senator BYRD. Thank you.

Now, you were too——

Secretary RICHARDSON. There are two $900 million figures. I think it would be clearer if we had it all written out.

Senator BYRD. Where is the other $900 million figure?

Secretary RICHARDSON. There is a total in the bill of $600 million for day care and training, and $300 million for administration, which is a cost of $900 million above existing programs, but not an increased cost in any recommendation before this committee above the House-passed bill.

The $900 million I was talking about a few minutes ago was a $900 million difference between the estimates that were before the House and the estimates that are before this committee. I had occasion several times during these hearings to point out that this $900 million is not a result of any recommendation that

was made in the light of earlier hearings. They are revised estimates under provisions of existing law for the AFDC and adult categories and the anticipation of higher food stamp costs because of the automatic checkoff.

So that is a $900 million difference in the total estimated costs now before this committee as compared with the estimates before the House. They are not, I repeat, costs attributable to the administration revisions themselves.

The other $900 million figure which was also before the House and which is a cost that does not apply under existing law, is part of the additional costs over what the Federal Government would otherwise pay. This $900 million is composed of the cost of administration due to the Federal assumption of administrative responsibilities under the family assistance plan, and the $600 million attributable to expanded day care services and work training opportunities.

Senator BYRD. Now, you were to supply for the record a reconciliation of the past and present cost estimates. Do you have those?

Secretary RICHARDSON. That is the paper we promised, Senator. I do not have it with me. I will see that you get it no later than tomorrow morning. I said this afternoon, but I had better give us a little more leeway. I do not know why you do not have it already.

Senator BYRD. Tomorrow morning will be satisfactory.

3 JULY 30, 1970

Senator BYRD. One other brief question, Mr. Secretary. You were going to supply for the record a reconciliation of the past and present cost estimates. Could we have those this afternoon?

Secretary RICHARDSON. That will be submitted to you in the morning.

Senator BYRD. Tomorrow morning?

Secertary RICHARDSON. Does the committee meet tomorrow morning, Mr. Chairman?

Senator ANDERSON. I do not know. If this is available at the time, please submit it.

Secretary RICHARDSON. I know you have not received the reconciliation yet. We owe it to you but we could not get it here today. We will have to do it tomorrow morning.

Senator BYRD. This goes back several weeks. I began to ask for it last week, but the committee asked for it some weeks before that. I realize that it sometimes takes time to get these matters out, but I am very anxious to get these figures. I think the committee is entitled to have them.

Secretary RICHARDSON. No question about that, Senator.

Senator BYRD. You plan to submit it to the committee and to me tomorrow morning, you say?

Secretary RICHARDSON. Yes.

Senator BYRD. Thank you.

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C., August 12, 1970.

Hon. ELLIOT L. RICHARDSON,
Secretary of the Department of Health, Education, and Welfare, Washington, D.C.

DEAR MR. SECRETARY: You will recall that on several occasions during your recent appearance before the Committee on Finance, I requested a reconciliation of the previous $8.2 billion cost estimate associated with the Family Assistance Act as it passed the House and the $9.1 billion estimate associated with the revised bill submitted by the Administration.

On August 1, I received from you a letter transmitting material which compared cost estimates associated with the House bill with estimates associated with the Administration's revision. Unfortunately, this material explained only in the most general terms the difference between the two estimates and it failed to show the cost effect of the various modifications in the Administration revision which would either increase or decrease the cost of the bill.

I am enclosing a table which shows what I had in mind as a reconciliation between the cost of the House bill and the cost of the Administration revision. I would appreciate it if you would be so kind as to have the blanks in the form filled out so that I will be in a position to evaluate the many changes you have proposed in the Administration revision.

Sincerely,

HARRY F. BYRD, Jr.

Estimate presented to House Ways and Means Committee:	Fiscal year 1971 (millions)
Family assistance payments	$3,800
Federal share of State supplementary payments to families	800
Payments to the aged, blind, and disabled	2,700
Increased administrative costs	300
Increased medicaid costs	100
Increased training costs	200
Increased child care costs	400
Total	8,200

Increases:	
1. Exclusion of income tax payments from consideration as income (sec. 443(a) on p. 9 of revised bill)	
2. Inclusion of children age 21 attending school full time (sec. 445(b)(2) on p. 14 of revised bill)	
3. Prohibition of lien affecting State supplementation of Federal benefits to families (sec. 452(c)(8) on p. 32 of revised bill)	
4. Revised definition of poverty levels (sec. 453 (c)(1) on p. 37 of revised bill)	
5. 2-year Federal assumption of full administrative costs prior to actual Federal takeover of administration of State supplementation program (sec. 461(a) on pp. 39–40 of revised bill)	
6. Increase in utilization of food stamps as a result of permitting welfare agency to purchase food stamps on behalf of welfare recipient (sec. 465 on p. 46 of revised bill)	
7. New authority for Federal grants for construction of child care facilities (sec. 436 on p. 56 of revised bill)	
8. Provision of $30 monthly incentive allowance to persons undergoing rehabilitation (sec. 437(d) on p. 60 of revised bill)	
9. Mandatory disregard of a portion of earnings of aged persons (sec. 1603(a)(5) on p. 87 of revised bill)	
10. New social services title:	
(*a*) Basic grants for social services (sec. 2010(a), p. 122)	
(*b*) Grants to assure more equal expenditures among the States (sec. 2010(b), p. 122)	
(*c*) Grants for foster care (see 2010(c), pp. 122–123)	
(*d*) Liberalized emergency assistance program (sec. 2010 (d), p. 123)	
(*e*) Project grants and contracts (sec. 2008, p. 119)	
(*f*) Grants to Governors and mayors (se 2009, p. 120)	
(*g*) Consolidated HEW plans (sec. 2021, p. 129)	
(*h*) Joint funding of interdepartmental programs (sec. 2030, p. 132)	
11. Extension of medicaid to persons age 21 (sec. 434(13) of revised bill, p. 142)	
12. Liberalization of saving provision (sec. 502 of revised bill, pp. 147–150)	
13. Additional supergrades for Department of Health, Education, and Welfare (sec. 505, pp. 152–153)	
14. Revision in estimate for payments to families as a result of increasing unemployment rate from 3.5 to 5 percent:	
(*a*) Family assistance payments	
(*b*) Federal share of State supplementation	
15. Other revisions in estimate for families eligible for welfare:	
(*a*) Family assistance payments	
(*b*) Federal share of State supplementation	
16. Revision in estimate for aged, blind, and disabled persons eligible for welfare	
17. Revision in estimate of medicaid costs	
Subtotal, increases	

Decreases:	Fiscal year 1971 (millions)
1. Penalty for refusing to work raised from $300 to $500 (sec. 447(a) on pp. 20–21 of revised bill)	
2. Tighter definition of suitable employment (sec. 448(b)(4) on pp. 25–26 of revised bill)	
3. Persons cut off the State welfare rolls because father is unemployed (sec. 451, p. 27)	
4. Persons cut off the State welfare rolls when Secretary sets State supplementation amount (sec. 452(a) of revised bill, p. 29)	
5. Persons having State welfare payment reduced when Secretary sets State supplementation amount (sec. 452(a) of revised bill, p. 29)	
6. Medicaid savings by cutting out families headed by women who receive State supplementary payments but not family assistance payments (sec. 455, pp. 38–39 and sec. 404(21), p. 145)	
7. Reduction in family planning costs due to deletion of requirement that family planning services be offered all appropriate welfare recipients (deleted sec. 103(b)(1)(I), p. 65)	
8. Limit work expenses for the aged, blind, and disabled to those related to their age, blindness, or disability (sec. 1603(a), p. 85)	
Subtotal, decreases	
Total, revised estimate	9,100

The CHAIRMAN. May I say that I think every member of this committee would like to have this information. It is rather difficult to vote on something not knowing whether it is going to cost $4, $6, $10, or $12 billion.

Now, the Senator from Virginia is a little more straitlaced about insisting upon knowing what something is going to cost than some other members of the committee. But, I must say that when the costs can vary by more than $1 billion, people who expect us to be responsible might hold us to account if we repeated the kind of fiasco that occurred on the medicaid when we were told the program was going to cost about a quarter of a billion dollars, and it ends up costing $3 billion. If this program should wind up costing ten times as much as its advocates project—and that is not at all beyond the realm of possibility—I just wonder how long people can expect to be elected to office or to stay in power if they are with the administration, if they continue to come up with programs that have completely irresponsible cost estimates, without even a late revision to show the increase in costs of the administration's own request. That will be in the record.

Senator TALMADGE. Mr. Chairman, may I make an observation?

The CHAIRMAN. The Senator from Georgia.

Senator TALMADGE. The cost of this program has concerned me greatly since it was first presented to this committee.

When former Secretary Finch appeared here before the committee in April, I asked him how the administration intended to finance the $4 billion-plus cost of the bill. He answered:

> Well, the Bureau of the Budget has built in these costs and all of their projections obviously were trading off with other programs. We have regarded the social implications of this as important enough to make those tradeoffs within our present projections.

Though he talked about tradeoffs, former Secretary Finch did not identify all of the programs the Administration plans to cut to pay for the welfare expansion bill.

On May 18 I wrote Secretary Finch asking him precisely what programs would be cut back. I never received an answer.

When Secretary Richardson appeared before the committee I asked him the same question. He replied at great length but did not answer the question. I then asked that Budget Director Schultz appear before the committee so that he could answer my question. He refused to appear.

Our budgetary situation is deteriorating. Few persons expect a budget deficit of less than $10 billion and some persons predict a deficit of twice that amount. The President has apparently recognized the seriousness of the situation since he has vetoed two spending bills plus a hospital construction bill within the last few months. I believe the Finance Committee is entitled to know how the administration intends to finance this $4 billion-plus welfare expansion bill before we proceed to act on it.

The CHAIRMAN. Well, Senator, I hope to get you that answer. I regret the information is not available. But in my efforts to try to find out, they indicate that the plan is to start with this bill first—this $4 billion at the bottom—and then to add interest on the national debt next, and then to build up from there and see where we come out.

Now, that is the best information I can obtain up to this point. I promise the Senator I will cooperate in helping to obtain that information.

Senator TALMADGE. I thank the distinguished Chairman.

The CHAIRMAN. Obviously, a lot of programs have to go out for that $4 billion, if we have any hope for a balanced budget.

The next witness will be Mr. Morris Campbell, owner and administrator of the Colony Home, Fitzgerald, Ga., on behalf of the American Nursing Home Association.

Senator TALMADGE. Mr. Chairman, it is a pleasure and a privilege indeed for me to welcome an old and valued friend and constituent, Mr. Campbell, and his associates from Georgia.

STATEMENT OF MORRIS D. CAMPBELL, JR., MEMBER, LEGISLATIVE COMMITTEE, AMERICAN NURSING HOME ASSOCIATION, ACCOMPANIED BY JOHN PICKENS, GENERAL COUNSEL, AND GERALD BISHOP, AMERICUS, GA.

Mr. PICKENS. Mr. Chairman and members of this committee, I am John Pickens; I am general counsel of the American Nursing Home Association.

In addition to Mr. Campbell, I have with me today Mr. Gerald Bishop from Americus, Ga., who is a nursing home administrator. He has a master's degree in hospital administration, was a hospital administrator for many years and has been in the health care field since 1951. He is also a fellow of the American College of Nursing Home Administrators. He is intermediate care conference chairman and a member of board of American Nursing Home Association.

Whereas our prepared written statement is rather long, our oral presentation will be much shorter, and Mr. Campbell will start out with the presentation.

Mr. CAMPBELL. The American Nursing Home Association is a nonprofit organization, representing both proprietary and nonproprietary long-term care facilities in 48 States. Its membership at the end of 1969 was 7,400 facilities, representing some 425,000 beds. Since the present year began, an additional 908 facilities with a bed capacity of over 50,000 have become members.

The association appreciates this opportunity to appear before the Senate Finance Committee. The testimony I will present is divided into three sections. The first section will be the association's views on a major amendment to H.R. 17550, proposed by the distinguished Senator from Utah, Mr. Bennett. I will then discuss those provisions of the bill as passed by the House of Representatives that are of primary concern to my association's members. The third section will be comments on desired changes that are not included in H.R. 17550.

Amendment No. 851 to H.R. 17550.

(a) Senator Bennett's proposal to establish Professional Standards Review Organizations (PSRO).

(b) PSROs should (1) insure that patients are placed in the least expensive type of facility that can satisfy the patient's needs, (2) identify facilities that are meeting appropriatee standards, (3) indentify cases of excessive or inadequate health services and take appropriate corrective action, and (4) work with all of the health professions and institutional providers to insure that health services are delivered efficiently and economically.

(c) The American Nursing Home Association supports Senator Bennett's amendment.

Discussion of H.R. 17550 as passed by the House of Representatives.

(a) Section 221: Limitation on Federal Participation for Capital Expenditures.

Federal programs support a high percentage of all long-term care patients; therefore, this limitation amounts to "franchising." The association is concerned over the ability of local and state planning agencies having the capability of making impartial decisions. ANHA recommends that the Secretary's decisions be subject to judicial review and that State and local agencies include representation of all providers on an equitable basis.

(b) Section 222: Prospective Reimbursement Experiments.

The Secretary has asked for authority to implement desirable methods of reimbursement as soon as they can be developed. ANHA supports his request. The bill does not specifically say that the experiments and demonstration projects should include financial incentives for providers as recommended by the staff of the Senate Finance Committee. An amendment is presented to include this clarification.

(c) Section 223: Limitations on Coverage of Costs.

(1) The Secretary is given authority to set "ceilings" on individual items of cost, such as food or utilities, as well as total cost. The bill does not clearly state that the limits cannot be applied retroactively, although the House Ways and Means Committee report clearly states that the limits would apply on a prospective basis. The bill should be amended to clarify this point.

(2) The bill authorizes providers to make excess charges after the Secretary has notified the public but does not establish procedures which would require the Secretary to provide the notice when appropriate. Procedures should be added to this section.

(3) The decisions of the Secretary should be based on hearings and subject to judicial review.

(d) Section 225: Establishment of Incentives for States to Emphasize Outpatient Care.

The Federal matching funds would be reduced for hospital, nursing home, and mental hospital services after specified numbers of days without consideration of the patient's medical needs. Regardless of the savings that may accrue, States would be forced to use lower cost facilities, that are unable to meet the patient's needs, or completely deny any assistance. Estimates of the financial impact on 22 States are included in the testimony. There are several existing or proposed controls on utilization. Controls begin with physician orders and a variety of systems already established by State agencies. Amendments to title XIX, passed by Congress in 1967 to be effective in 1969, include several controls; but the Secretary did not publish proposed regulations until May of this year, and final regulations have not been published. H.R. 17550, sections 223, 235, and 238, provides for utilization review, advance approval of admissions which could be made applicable to title XIX, and State health agency plans for professional review of utilization. In addition, Senator Bennett's amendment would greatly improve controls. Utilization should be based on medical necessity and not by withholding Federal funds, regardless of patient's needs. Section 225 should be deleted.

(e) Section 227: Authority of Secretary To Terminate Payments.

The Secretary should have authority to control abuses by terminating payments to abusers of the programs.

(f) Section 230: Amount of Payments Where Customary Charges Are Less Than Reasonable Costs.

No objections.

(g) Section 231: Institutional Planning Under Medicare Programs.

Capital expenditures budgets and operating financial plans are essential to any well-run business, but making them a requirement would mean that they would have to be revealed to enforcement agencies and possibly become public records. The detail information in these documents is often confidential, and public knowledge of them could be harmful. Section 231 should be deleted.

(h) Section 233: Advanced Approval of Extended Care and Home Health Coverage Under Medicare.

Advanced approval would improve utilization and help solve the problem of retroactive denials.

(i) Section 235: Utilization Review Requirements for Medicaid and Maternal and Child Health Programs.

Recommend adoption.

(j) Section 254: Physical Therapy Services.

This section, among other provisions, limits payment to institutions for therapy costs to the amount that would normally be paid as salary if the therapist was an employee. Many therapists in private practice would not accept the lower level of payment, and extended care facili-

ties could not absorb the differences. Adoption of this provision in section 254 could eliminate participation of large numbers of ECFs in the program.

Mr. Pickens will now discuss judicial review.

Mr. PICKENS. As Mr. Campbell has said, Mr. Chairman, our association enthusiastically supports Senator Bennett's amendment, and we feel that one board or one group should be responsible for the review of all providers in the community, and we feel that his amendment will probably go further, to cut the costs of this program and to put the patient in the proper facility—be sure that the patient is getting the right care and the right facilities, of any other proposal that has ever been made.

I know some associations that have objected to it because they do not have representation on these local groups. Local PSROs are made up entirely of the physicians, and I would think this might be aided by having an advisory board to this group on which there could be representatives of all providers.

But I think fundamentally that his amendment is sound and it should be the physicians who are the ones that provide the review.

There are two other sections of the act that we feel should be amended in order to strengthen Senator Bennett's bill.

As the members know, the hospitals are automatically eligible for medicare if they are accredited by the Joint Commission on Accreditation of Hospitals.

In 1965, when the medicare was adopted, the Joint Commission on Accreditation of Hospitals was not then accrediting extended care facilities. But 2 years later they started accrediting extended care facilities.

We believe that either the extended care facilities should be added to this section, which would make them automatically eligible, or the hospitals should be removed from the section because you have two standards: One for one provider and another for another provider.

I know Secretary Finch, and I think, the Secretaries prior to him who testified before this committee before, felt that whereas they had tightened up the custodial care regulations in regard to extended care facilities, they were powerless to do so in hospitals because of this provision making hospitals automatically eligible if they are accredited by the Joint Commission. We feel either the ECF should be added to the sections or the hospitals should be deleted.

The second thing we feel that is necessary to assure the strengthening of Senator Bennett's amendment is that the free days allowed in hospitals, and the free days allowed in extended care facilities, at least should be the same. The average length of stay for extended care patients in the hospital prior to the time they came to the extended care facilities is running between 25 and 30 days throughout the Nation, whereas the average length of stay in the ECF these same patients, is around 35 to 40 days, and where you have only 20 free days in EEF's and 60 free days in the hospitals, and you have the Secretary tightening up and cracking down, so to speak, on custodial cases in extended care facilities, the tendency is natural for the family to apply pressure to the physician to keep the patient in the hospital, because they are afraid that once the patient is trans-

ferred from the hospital to the extended care facilities, that his benefits are going to be denied, and this is what has happened.

Once the family has already paid the deductible so that they have 60 free days in the hospital, then, I think, you can see that any family would be concerned that after the patient had been in the hospital 20 or 25 days, if they then transferred him to an ECF, and there is a chance that they would not obtain ECF benefits, the tendency would be to pressure the physician to keep him in the hospital.

Of the other two or three points that we wish to make, one is on judicial review.

Medicare is the only major Government program where the Government is regulating an industry or field where the rules and the regulations and the other actions of a Government agency are not subject to the administrative or judicial review.

Now, the Supreme Court in four cases in March of this year has greatly broadened judicial review in every situation, and they have held that in actions of Government agencies that judicial review is more or less a constitutional right unless Congress has specifically prohibited judicial review.

Congress has prohibited judicial review in title XVIII, except in two instances, and one is where the Secretary refuses to grant eligibility to an extended care facility or to some other provider, or where the Secretary terminates his eligibility or his contract. These are the only two instances, and this has been tested in a half dozen cases in the Federal courts, and in each instance—and we refer to some of them in our testimony, written testimony, pages 21 and following—in every instance the court has held that they lacked jurisdiction because Congress intended and did preclude judicial review.

Now, this seems anomalous because the Administrative Procedure Act of almost every State—and we have not found a State yet otherwise—allows judicial review of the actions of State health and welfare commissioners, and there have been several cases brought, and we refer to two or three of them on pages 22 and 23, where in California, in New York and in almost every State they can question and can obtain judicial review of actions of State welfare commissioners. We feel it is somewhat anomalous that the Federal Government should not allow judicial review in a section or in an area where all the States allow it, and even where the Federal Government allows it in all other situations except in this field.

We feel that because of the fact that the Secretary is isolated from judicial review that many of those who are making the decisions in the Department realize this, and we question, and we have questioned, many of their actions as being arbitrary, but we have no appeal. This is the only instance that we can find in a procurement situation where the agency acts as a legisator, in a way, and a prosecutor and a judge and jury all combined, without any restraints except its own restraint.

We feel that the Congress would be greatly aided by some judicial light on some of the regulations and some of the actions of the Department of Health, Education, and Welfare and the Social Security Administration.

The other point we wish to make is—and we have testified to this point, I think, at every hearing since medicare—we feel that the

Department's definition of "spell of illness" is discriminatory, and we feel it is arbitrary.

Congress itself defined a spell of illness in section 1861, but the Department has gone beyond that definition.

You will recall that "spell of illness" is defined as the stay that the patient stays in a hospital and then goes to an extended care facility, and that he must not be a patient in either one of these two facilities for 60 continuous days. It is discriminatory because if a patient is in a residential care home or even in an intermediate care home where you have just one licensed practical nurse in charge, if this patient then goes to the hospital and goes from the hospital to an ECF, and then from an ECF back to where they are residing in this personal care home, they never again are entitled to medicare benefits. We feel this is a great injustice. Perhaps, it is a money-saving regulation on the part of the Department, but I doubt if it saves very much money.

It is very discriminatory to the elderly people at the present time, who have to live in a residential care home or in a home where there is some nursing service.

The Congress has defined this section as a spell of illness, as 60 days when a patient is not in either a hospital or an extended care facility or a skilled nursing home. This was really the way the Congress defined it, not in so many words, but the Department has gone beyond that and has said for the purposes of a spell of illness an "extended care facility" will be considered any facility that has one licensed practical nurse or more.

We think this is a situation that is causing great hardship to a few elderly individuals who do not have a home of their own. If they had a home of their own, and they went to the hospital, and they went to an extended care facility, and they returned to their own home, they could have 100 home health care visits during the same period, and there, even though they have these 100 home health care visits, they would be starting a spell of illness, this 60 day period, and they, at the end, would be eligible for medicare benefits if they got sick the following year.

But, if this patient is elderly and being sick enough that they have to be in a residential health care home, with one LPN, they have just one shot at medicare, and never again can they have a medicare benefit.

We think this is very discriminatory, and we think it is against the intent of Congress, because Congress defined a spell of illness, but the Department has gone beyond that definition.

The other part, and this is in conclusion, we feel that the rulemaking on the part of the Secretary of Health, Education, and Welfare, and the Social Security Administration should be subject to the Administrative Procedure Act.

We feel that in all cases the ratemaking, like the fixing of the reasonable cost formula, and so forth, that in almost every instance before every administrative agency in the ratemaking situation, one should have the right to a hearing on the record. In every State that has a formula where they fix a welfare rate, unless it is a negotiated rate, it is required by State act that these rules and regulations be not implemented until after there has been a hearing, adequate notice and a hearing on the record.

We feel the same thing should apply to the rules and regulations that the Secretary is given authority to promulgate under section 1861 of the act.

Senator ANDERSON. Thank you very much for your presentation. We will have to hurry a bit because of a vote on the floor, and we appreciate the contribution that you have made.

Mr. PICKENS. Thank you for your indulgence.

(Mr. Pickens' prepared statement follows. Hearing continues on p. 701.)

TESTIMONY OF THE AMERICAN NURSING HOME ASSOCIATION—SUMMARY

I. INTRODUCTION OF PERSONS APPEARING ON BEHALF OF THE ASSOCIATION

II AMENDMENT NO. 851 TO H.R. 17550.

a. Senator Bennett's proposal to establish Professional Standards Review Organizations (PSRO).

b. PSROs should (1) insure that patients are placed in the least expensive type of facility that can satisfy the patient's needs, (2) identify facilities that are meeting appropriate standards, (3) identify cases of excessive or inadequate health services and take appropriate corrective action, and (4) work with all of the health professions and institutional providers to insure that health services are delivered efficiently and economically.

c. The American Nursing Home Association supports Senator Bennett's amendment.

III. DISCUSSION OF H.R. 17550 AS PASSED BY THE HOUSE OF REPRESENTATIVES

(a) Section 221: Limitation on Federal participation for capital expenditures

Federal programs support a high per centage of all long-term care patients; therefore, this limitation amounts to "franchising." The Association is concerned over the ability of local and state planning agencies having the capability of making impartial decisions. ANHA recommends that the Secretary's decisions be subject to judicial review and that state and local agencies include representation of all providers on an equitable basis.

(b) Section 222: Prospective reimbursement experiments

The Secretary has asked for authority to implement desirable methods of reimbursement as soon as they can be developed. ANHA supports his request. The bill does not specifically say that the experiments and demonstration projects should include financial incentives for providers as recommended by the staff of the Senate Finance Committee. An amendment is presented to include this clarification.

(c) Section 223: Limitations on coverage of costs

(1) The Secretary is given authority to set "ceilings" on individual items of cost, such as food or utilities, as well as total cost. The authority should be limited to total cost. The bill does not clearly state that the limits cannot be applied retroactively, although the House Ways and Means Committee report clearly states that the limits would apply on a prospective basis. The bill should be amended to clarify this point.

(2) The bill authorizes providers to make excess charges after the Secretary has notified the public but does not establish procedures which would require the Secretary to provide the notice when appropriate. Procedures should be added to this section.

(3) The decisions of the Secretary should be based on hearings and subject to judicial review.

(d) Section 225: Establishment of incentives for States to emphasize outpatient care

The federal matching funds would be reduced for hospital, nursing home, and mental hospital services after specified numbers of days without consideration of the patient's medical needs. Regardless of the savings that may accrue, states would be forced to use lower cost facilities, that are unable to meet the patient's needs, or completely deny any assistance. Estimates of the financial impact on

22 states are included in the testimony. There are several existing or proposed controls on utilization. Controls begin with physician orders and a variety of systems already established by state agencies. Amendments to Title XIX, passed by Congress in 1967 to be effective in 1969, include several controls; but the Secretary did not publish proposed regulations until May of this year, and final regulations have not been published. H.R. 17550, Sections 233, 235, and 238, provides for utilization review, advance approval of admissions which could be made applicable to Title XIX, and state health agency plans for professional review of utilization. In addition, Senator Bennett's amendment would greatly improve controls. Utilization should be based on medical necessity and not by withholding federal funds, regardless of patient's needs. Section 225 should be deleted.

(e) Section 227: Authority of Secretary to terminate payments

The Secretary should have authority to control abuses by terminating payments to abusers of the programs.

(f) Section 230: Amount of payments where customary charges are less than reasonable costs

No objections.

(g) Section 231: Institutional planning under Medicare programs

Capital expenditure budgets and operating financial plans are essential to any well-run business, but making them a requirement would mean that they would have to be revealed to enforcement agencies and possibly become public records. The detail information in these documents is often confidential and public knowledge of them could be harmful. Section 231 should be deleted.

(h) Section 233: Advanced approved of extended care and home health coverage under Medicare

Advanced approval would improve utilization and help solve the problem of retroactive denials. The bill should be amended to include Medicaid admissions from hospitals.

(i) Section 235: Utilization review requirements for medicaid and maternal and child health programs

Recommend adoption.

(j) Section 254: Physical therapy services

This section, among other provisions, limits payments to institutions for therapy costs to the amount that would normally be paid as salary if the therapist was an employee. Many therapists in private practice would not accept the lower level of payment and extended care facilities could not absorb the differences. Adoption of this provision in Section 254 could eliminate participation of large numbers of ECFs in the program.

IV. COMMENTS ON DESIRED CHANGES THAT ARE NOT INCUDED IN H.R. 17550

(a) Judicial review

Courts have held that the decisions of the Secretary concerning providers are subject to judicial review only on questions of eligibility to participate on terminations of participation. There have been several actions of the Secretary where compliance with the intent of Congress could be questioned. Virtually all states allow more extensive judicial review than is permitted under Medicare. An amendment is presented in the testimony that would permit judicial review when the claim exceeds $10,000.

(b) Medicare benefit structure

The benefit structure for hospital and extended care facility services encourages use of the hospital. Modification of the number of "free" days and a reduction of total benefit days with an additional allowance for catastrophic illness would partly rectify the situation. Two amendments are presented in the testimony.

(c) Definition of "spell of illness"

The spell of illness concept requires that the patient be out of a hospital or a facility that provides skilled nursing care for 60 days before a new period of eligibility begins. The Secretary has ruled that the spell of illness cannot be broken if the patient is in any facility which is under the supervision of a li-

censed practical nurse. Many patients in nursing homes, intermediate care facilities, or even custodial care facilities which employ a licensed nurse are deprived of Medicare benefits. Two amendments are presented in the testimony to correct the problem.

(d) Rule-making—hearings on the record

Present rule-making procedures do not provide adequate opportunity for presentation of facts or records for review. A proposed amendment is presented that would require adequate notice, opportunity for hearing and participation by interested parties when rules on more substantive matters are being adopted.

STATEMENT

Mr. Chairman, and members of the Committee, I am Morris D. Campbell, Jr., owner and administrator of the Colony Home, a 143-bed nursing home in Fitzgerald, Georgia. Colony Home is fully certified as an extended care facility.

I have been in the nursing home field since 1958 and am the immediate past president of the Georgia Nursing Home Association, president of the Georgia Chapter of the American College of Nursing Home Administrators and a member of the Legislative Committee of the American Nursing Home Association.

The American Nursing Home Association is a nonprofit organization, representing both proprietary and nonproprietary long term care facilities in 48 states. Its membership at the end of 1969 was 7,400 facilities, representing some 425,000 beds. Since the present year began, an additional 908 facilities with a bed capacity of over 50,000 have become members.

The Association appreciates this opportunity to appear before the Senate Finance Committee. The testimony I will present is divided into three sections. The first section will be the Association's views on a major amendment to H.R. 17550, proposed by the distinguished Senator from Utah, Mr. Bennett. I will then discuss those provisions of the bill as passed by the House of Representatives that are of primary concern to my Association's members. The third section will be comments on desired changes that are not included in H.R. 17550.

AMENDMENT NO. 851 TO H.R. 17550

Amendment No. 851, proposed by Senator Bennett and referred to the Committee on Finance on August 20, 1970, would materially alter present systems of utilization review, which are intended to control unnecessary and excessive usage of institutional care. The Professional Standards Review Organizations (PSRO), established under the amendment, also would supplement or replace other efforts to insure that only services necessary to proper health care are provided; that those services are consistent with professional standards; and that, where appropriate, less costly alternative modes and sites of health care are used. Mr. Bennett has spoken to the Senate on two occasions concerning his proposal, and I am sure that he and others have already explained the provision of the amendment to this Committee. Therefore, I briefly will call your attention to those results which the American Nursing Home Association would like to be achieved.

We have consistently stated that improved, realistic, and innovative utilization of the various forms of less costly institutions encompassed in the generic term "nursing homes" offers the greatest single potential for reducing the cost of health care. For example, there is no reason why nursing homes should be characterized as facilities for the elderly, other than the fact that current usage is largely limited to the elderly. The Association would like to see PSROs develop the capability of evaluating the health services available in all care facilities in the area and be able to match patient needs with the least expensive type of facility that can satisfy those needs.

The PSROs should have the ability to evaluate facilities in terms of standards that are necessary to meet patient needs and inform the community on which facilities are maintaining those standards.

ANHA would like the PSROs to evaluate the patients' needs in terms of health services ordered by the physician and provided by ancillary medical personnel, such as therapists, or by the facility. Where cases of excessive or inadequate health care services are identified, it is our hope that the PSROs will have the necessary respect of the health care community and the authority to insure that appropriate corrective action is taken.

ANHA expects that PSROs will work with all of the medical professions and institutional providers to insure that patients receive the appropriate medical services through the most efficient, economical methods.

The health care delivery systems and the controls existing today are not getting the job done. The American Nursing Home Association supports Senator Bennett's amendment, because we agree that responsible physicians, working closely with other health professionals and institution administrators in the community through Professional Standards Review Organizations, offer a real possibility for improvement.

DISCUSSION OF PROVISIONS OF H.R. 17550 AS PASSED BY THE HOUSE OF REPRESENTATIVES

Section 221—Limitation on Federal participation for capital expenditures

The proposal limits federal payments to institutions when capital expenditures are disapproved by planning agencies. This provision, when applied to the field of long-term institutional care, has a much greater potential effect than when applied to other types of facilities. The federal programs (Titles XVIII and XIX) contribute to the support of approximately 75% of all patients in non-hospital based Extended Care Facilities and Skilled Nursing Homes. Controls on capital investments by the proposed disallowance of capital related expenditures in computing the reimbursement is an indirect form of "franchise," since relatively few facilities can operate without participating in the federally supported programs.

The members of ANHA are deeply concerned that the planning agencies, which, in effect, will function as franchise boards, will have almost unlimited power to control the long-term care field by their recommendations to the Secretary.

The planning agencies frequently must decide between two or more capital expenditure proposals to satisfy a particular need in an area. There are an almost unlimited number of factors that can be considered in making such a decision. It is not improbable that decisions can be influenced by personal or quasi-political factors. The relatively recent development of Comprehensive Health Planning organizations under P.L. 89-749 raises the serious question of whether or not these agencies have developed adequate techniques to properly discharge the functions and properly exercise the authority which the proposed section 221 will assign to them.

During hearings in October, 1969, the Department of Health, Education, and Welfare provided the House Ways and Means Committee the following information:

The Comprehensive Health Planning Program is still in a developmental and organizational stage. State agencies have been established in all 50 states, the District of Columbia, and 5 territories. On the areawide level, 106 planning agencies, servicing slightly more than half the population of our nation, are receiving federal grants; 10 of such agencies are currently operational. It is estimated that 113 planning agencies will be receiving grants by the end of fiscal year 1970 and that 35 of such agencies will be operational.

In the event Section 221 is adopted, we recommend that the decisions of the Secretary be subject to judicial review. The American Nursing Home Association also recommends that the planning agencies, both state and local, include representation of all providers on an equitable basis.

Section 222—Prospective reimbursement experiments and demonstration projects to develop incentives for economy in the provision of health services

The section increases the Secretary's authority to conduct experiments and demonstration projects, but it does not authorize elimination of the "reasonable cost" concept. The fact that the proposal broadens the existing authority of the Secretary to experiment with payment programs and directs the Department to conduct demonstration projects is a step in the right direction. However, the wide acceptance of the fact that the present "reasonable cost" reimbursement concept has already demonstrated its shortcomings indicates the need for more rapid changes than the House-passed bill permits.

Secretary Richardson, when testifying before this Committee in July, recommended that the bill be revised to provide authority for the Department to implement desirable methods for reimbursement as soon as they can be worked out by agreement with providers without having to wait for further congressional action. Unless the present proposal is revised, the Secretary would not report

back to Congress until July of 1972, and it would be 1973 at the earliest before the discredited "reasonable cost" concept could be eliminated. We hope that this Committee will accept Secretary Richardson's recommendations.

We firmly believe that the incentive reimbursement authority granted the Secretary to participate in pilot projects has failed to attract but a few proposals and has resulted in little progress, because such authority has been construed to allow no reward to the provider of service for reducing costs. Hence, this section provides no incentive to a provider to attempt to develop a project to cut costs. It is a one-sided proposal—only to save the government money. It does not allow the principles of competitive free enterprise to operate. The report of the Staff of the Senate Finance Committee of February 9, 1970 (91st Congress, 1st Session, Committee Print) recognized this at page 89 and recommended that the costs saved the federal government be shared with the provider. We have suggested in our amendment in Appendix B, Section I, that the Secretary be authorized to enter experiments with such true incentive factors.

Section 223—Limitations on coverage of costs under the medicare program

This section authorizes the Secretary to set "ceilings" on the various elements of cost, such as food, supplies, salaries, etc. Providers are authorized to charge patients for costs in excess of the "ceilings" under specified conditions. The authority granted the Secretary by this section to exclude "any part of incurred costs found to be unnecessary in the efficient delivery of needed health services" appears to expand and clarify the authority that has been used by the Secretary since the beginning of the Extended Care Facility program. The Secretary through the intermediaries, has set ceilings on rates of payment based on costs incurred by other facilities in the area. The expansion of this authority to establish limits on specific items or services, or groups of items or services, will be interpreted as a legislative "mandate" rather than "authorization." The cost of making the necessary determinations on the many cost factors involved will add to the already prohibitive cost of administering the program. The often mentioned "audit overkill" will be perpetuated and expanded.

The American Nursing Home Association accepts the concept that the program should not pay for all costs simply because they have been incurred, but establishing maximums on total costs will provide an adequate control.

The proposed amendments do not mention whether the Secretary has authority to establish the limits retroactively. Our experience indicates that if the authority is not limited, the Secretary will advise facilities that expenses incurred several years in the past will be disallowed and retroactive adjustments required. The reports of the Committee on Ways and Means on H.R. 17550 (Pg. 33) clearly states that the authority would be exercised on a prospective basis. The proposed section should be amended to require the Secretary to advice the facility of any limits on costs prior to the time the provider delivers the service to eliminate any possibility of misinterpreting the Congressional intent.

The proposal makes no provision for hearings or judicial review of ceilings established by the Secretary. The section should be amended to require that the Secretary's determination will be made only after an administrative hearing, and any provider dissatisfied with such determination shall have the right of judicial review.

The provisions which establish the basis on which the provider can charge the beneficiary for excess costs are supportive of the original intent that the right of the beneficiary to free choice of institution is guaranteed. However, the present wording permits the provider to make the excess charge only when the Secretary has provided notice but does not specifically require the Secretary to provide such notice. Although the intent may be clear, the section should be amended to establish a procedure whereby the provider can apply for authority to make the excess charge and time limits during which the Secretary must act on the application and provide the public notice.

The section requires that the amount of payment due to a provider be reduced to the extent that such payment plus the excess charges exceed the cost actually incurred.

A provider can impose the excess charges only to the extent that the actual costs experienced in the second fiscal year preceding the fiscal period when the charges are made exceed the limit set by the Secretary. In addition, the excess charges cannot exceed the customary charge; the Secretary must advise the public of the excess charge; and the provider must notify the patient in accordance with regulations to be published. It would appear that the conditions which must

be met before the excess charge can be made would be adequate protection of the patient without the additional expense of redetermining the actual cost during the period the services were provided and making the proposed reduction.

Section 225: Establishment of incentives for States to emphasize outpatient care under medicaid program.

The proposal contains five (5) principle provisions:

(1) The Federal matching per centage for outpatient hospital services, clinic services, and home health services would be increased by 25%,

(2) The Federal per centage after the first 60 days of care in a general or TB hospital would be reduced by one-third,

(3) The Federal per centage after the first 90 days of care in a year in a skilled nursing home would be reduced by one-third,

(4) The Federal matching for care in a mental hospital after 90 days of care would be reduced by one-third, and no Federal matching would be available after 275 days of such care during an individual's lifetime, and

(5) The Secretary would be authorized to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

The stated purpose of the provisions is to encourage states to require the use of lower cost methods of providing health services to patients receiving benefits under Title XIX when more expensive institutional health services are not medically necessary.

The actual effect will be the reduction of the federal per centage after the stated period, with no consideration of medical necessity.

Regardless of the possible savings that may accrue from the anticipated reduction of the use of unnecessary higher cost services, the added financial burden on states will force the use of lower cost services or the complete denial of benfits when "skilled nursing home services" are medically necessary. If non-grant recipients requiring skilled nursing home services are placed in Intermediate Care Facilities as an inadequate alternative, no federal financial assistance will be provided.

The financial impact on states as a result of the proposal is difficult to obtain, but estimates from a few states are available:

	1971
Alabama	$4,000,000
California	20,400,000
Colorado	4,000,000
Connecticut	2,000,000
Georgia	7,400,000
Idaho	818,629
Indiana	1,041,000
Louisiana	4,250,000
Maryland	5,421,700
Massachusetts	5,000,000
Nebraska	3,500,000
New York	105,000,000
North Carolina	2,500,000
Oklahoma	18,000,000
Pennsylvania	13,100,000
South Carolina	2,734,959
Tennessee	8,000,000
Texas	9,167,230
Utah	2,000,000
Washington	1,288,000
Vermont	1,083,032
Virginia	2,420,000

We would like to call the Committee's attention to the existing and proposed methods of determining medical necessity, which are intended to insure appropriate utilization of skilled nursing homes.

The first step is the patient's physician's order for admission. At that point, states have established a variety of review mechanisms, such as requirements for written approval by local representatives of the agency administering the program, classification of patients into various levels of care categories, utilization review programs, etc.

The 1967 amendments included a provision effective July 1, 1969, requiring states to establish "a regular program of medical review (including medical evaluation of each patient's need for skilled nursing home care) or (in the case of individuals who are eligible therefore under the state plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing home . . ." These 1967 amendments also require periodic inspections by medical review teams in skilled nursing homes and mental institutions of the care being provided, the adequacy of the services available to meet the current health needs of each patient, the necessity and desirability of the continued placement of the patients, and the feasibility of meeting their health needs through alternative institutional or noninstitutional services. Tentative regulations to implement these requirements were not published by the Secretary until May 16, 1970, and final regulations have not been adopted. Enforcement of these existing legislative requirements should accomplish a major part of the stated intent of the proposed section 225.

H.R. 17550 and proposed amendments already before the Committee include other provisions intended to control utilization.

Section 235, if adopted, would require the same or similar utilization review procedures under Medicaid that are presently required under Medicare. Section 233 provides procedures for advance approval of Extended Care and Home Health Coverage under Medicare. This procedure could be extended to skilled nursing home admissions of patients being discharged from hospitals. Section 238 requires State Health Agencies to establish a plan for review by professional health personnel of the appropriateness and quality of care and services under the Medicaid and Maternal and Child Health programs.

The amendment to H.R. 17550 proposed by Senator Bennett to establish Professional Standards Review Organizations would greatly improve present methods of determining the medical necessity of institutional care.

The existing procedures, existing legislation if enforced, the various proposals in H.R. 17550, and Senator Bennett's amendments should control utilization of the more expensive institutional care services through the exercise of professional judgment on medical necessity. Section 225 would withhold federal funds without consideration of patients' needs.

Recommend that Section 225 be deleted.

Section 227—Authority of Secretary to terminate payments to suppliers of services

The section permits the Secretary to discontinue payments to providers that abuse the program. The American Nursing Home Association has consistently stated that individuals and institutional providers which abuse the program should be identified and their participation in the program terminated. If this approach to the problem of abuse had been rigorously followed rather than the common practice of publishing more regulations, which usually results in onerous burdens and administrative costs, the patients, the provider and the program would all have benefited.

Our only concern with the proposal is that deliberate abuse not be mistaken for honest errors and human misunderstandings because of the morass of confusion that has surrounded both programs.

We recommend that Subsection A on page 110, line 18, be amended to read "(A) has made knowingly, or knowingly caused to be made, any false . . . etc." The same amendment should be made on page 113, line 19.

Section 230—Amount of payments where customary charges for services furnished are less than reasonable cost

This section limits payments to the amount of the provider's customary charges. The American Nursing Home Association has no objections to limiting payments to Extended Care Facilities under Title XVIII or Skilled Nursing Homes under Title XIX to customary charges established by the owners or administrators for private paying patients for similar services. The bill should be amended to clarify that rates established by governmental programs are not considered customary charges.

Section 231—Institutional planning under medicare program

Requires facilities to have a three-year financial plan for capital expenditures and an annual operating budget of income and expenses. The objective of the previous Section 221, requiring approval of capital expenditures, is clear; and, although it is contrary to some of the basic principles of the free enterprise system, the American Nursing Home Association and its members understand the

rationale underlying the proposal. The Association also recognizes the desirability of any business enterprise operating under modern management principles having a financial budget including both operating and capital expenditures. However, we seriously question the advisability of requiring a facility to have a financial plan as a condition of participation in Medicare.

A financial plan is a highly sensitive document in any business, and the revelation of its contents could have adverse effects. The enforcement of the proposal would require availability for study by representatives of certifying agencies, with the consequent possibility of its confidentiality being compromised.

Sources for capital funds vary, but in most cases, negotiations for capital investments and loans are kept confidential until final commitments are made. It would be unusual that a three-year capital expenditure budget could indicate the specific sources of funds. Companies which rely on public sales of stock may be restricted by Security and Exchange Commission rules from making financial plans available for inspection by representatives of state certifying agencies.

The proposed requirement and the actions necessary for its enforcement would be an unwarranted invasion of privacy that cannot be justified by the rather altruistic motive of attempting to force health care institutions to adopt the common management practice of developing financial plans.

ANHA recommends that Section 231 be deleted.

Section 233—Advance approval of extended care and home health coverage under medicare program

The section established procedures for advance approvals of additional types of care after discharge from a hospital. The proposal provides a partial solution to one of the major problems experienced by Extended Care Facilities participating in the Medicare program. Retroactive denials by fiscal intermediaries, in accordance with the Department's definitions of medical eligibility, have resulted in the establishment of strict admission requirements, which, in effect, deny eligible patients the care to which they are entitled. Physicians have tended to retain patients in hospitals, where there is greater certainty of Medicare reimbursement. Much more could be said concerning the problems that this proposed amendment is designed to cure, but we will simply say that this section, combined with the Professional Standards Review Organization proposed by Senator Bennett, will insure that patients are placed in institutions providing the level of care appropriate to their medical needs.

ANHA recommends the adoption of Section 233. We also see no reason why the proposal applies only to the Medicare program. In order for the full benefits to be achieved, the section should be amended to include advanced approvals of skilled nursing home admissions from hospitals under Title XIX (Medicaid).

Section 235—Utilization review requirements for hospitals and skilled nursing homes under medicaid and maternal and child health programs

The proposal to require the same or similar utilization review requirements for "skilled nursing homes" under Title XIX as that required by Title XVIII is supported by the American Nursing Home Association. Many States are already requiring utilization review, and large numbers of nursing homes have established utilization review teams voluntarily. Nursing homes normally do not have a medical staff and have established a variety of forms of utilization review. There is a consensus that the most effective forms are those which have been organized through arrangements with local medical societies. For this reason, we hope that Senator Bennett's amendment is adopted and support Section 227 as an interim step to assure the appropriate placement of patients and the provision of institutional health care in accordance with each patient's medical needs.

Section 237—Notification of unnecessary admission to a hospital or extended care facility under medicare program.

Requires that the facility be advised when the utilization review team determines that a patient does not need the services being provided and that payment be terminated. Utilization Review programs in Extended Care Facilities have included notifications when any case is reviewed, and a determination is made that the patient does not need the level of care being provided.

The American Nursing Home Association recommends the adoption of Section 237, with the additional recommendation that the section be applicable to the institutional providers under the Title XIX program.

Section 254—Physical therapy services under the medicare program

The American Nursing Home Association is concerned particularly with the proposed provision which would limit the cost of physical therapy service to the amount equal to the salary which would be paid if they had been performed under an employment relationship. Non-hospital based Extended Care Facilities normally provide therapy services through arrangements with therapists rather than by employment of full-time therapists. In general, the amount of therapy required does not warrant the employment of a therapist as a member of the staff. Under these circumstances, the therapist continues to have the same costs for the maintenance of his office and therapy facility. In addition, the therapist has the added cost of traveling to the patient and the time away from his office practice.

Limiting reimbursement to the Extended Care Facility to the salary level of an employed therapist rather than reasonable charges will result in the facility absorbing the difference or reducing the payment to the therapist. A reduction in payment to the therapist would result in the therapist terminating the arrangement with the facility. The Extended Care Facility would be unable to obtain therapy services for its patients and would be unable to continue in the program. Adoption of this particular provision of Section 254 probably will eliminate the participation of large numbers of Extended Care Facilities in the Medicare program.

Comments on Desired Changes That Are Not Included in H.R. 17550

JUDICIAL REVIEW

Medicare is the only major government program where government is regulating an industry or field (and also procuring all of government's requirements from the provider that it is regulating) where the rules, regulations or other actions of the government agency is not subject to administrative or judicial review.

In *Aquavella* v. *Finch* (the Glen Oaks Case), 306 F.Supp. 860, 863, W.D. N.Y., 1969), Judge Henderson, June 30, 1969, the Court held that a "provider" of services under the Medicare Act can bring an action for judicial review of a determination of the Secretary in two instances ONLY, (1) where the Secretary determines that the provider is not eligible to participate in the Medicare program, and (2) where the Secretary terminates the provider's contract and holds the provider not to be further eligible. To the same effect are several other Federal court decisions.

The Medicare Act requires that in promulgating regulations (1) that the Secretary (a) consult with national organizations and (b) refer the proposed regulations to the Health Insurance Benefits Advisory Council (HIBAC), and the Administrative Procedure Act requires (2) that the proposed regulations be published in the Federal Register, and (3) comments solicited before it is finalized, codified and enforced.

The original "Conditions of Participation for Extended Care Facilities," as well as the original "Principles of Payment" went through this required process. However, during the past 3 years, over 1,000 state agency letters, intermediary letters and other instructions, written and oral, have been promulgated, drastically modifying the "Conditions of Participation and Principles of Payment," and with few exceptions, not one of them has been issued pursuant to the due process requirements of the Medicare Act or the Administrative Procedure Act.

In other words, the industry or national associations were not consulted, the proposed changes were not referred to HIBAC and were not published in the Federal Register for comments before implementation. To add to such arbitrary action, countless important changes and amendments were made retroactive for periods in excess of two years.

For example, actions of the Defense Department adversely affecting a government supplier are subject to review by the Armed Forces Board of Contract Appeals as well as by other Boards of Contract Appeals. The Defense Department does not begin to regulate its government suppliers to the extent that the Department of Health, Education and Welfare and the Social Security Administration do. Yet it has a review process. In addition, it should be noted that the Medicare Act gives the Secretary more discretionary power to issue rules and regulations than in almost any other piece of Federal legislation. Certainly, some review of his actions should be allowed, especially since he has delegated so

much of his authority to the Social Security Administration as well as to the various divisions of the Department such as the Medical Services Administration and others.

The Administrative Procedure Act of almost every state allows judicial review of actions of the State Health or Welfare Commissions. Recently, the Court of Appeals for the State of California (Third Appellate District) in *California Association of Nursing Homes v. Spencer W. Williams, Administrator of the Health and Welfare Agency of California*, Cal. App. 2d, March 24, 1970, held that a provider in California could sue the state where the state agency had not followed procedural due process in fixing reimbursement rates for nursing homes.

In Catholic Medical Center of Brooklyn v. Rockefeller (U.S.D.C.E.D.N.Y), No. 69-C-641, 305 F.Supp. 1268 (1969), a three judge statutory composed court (required because constitutionality of state law was raised) held two hospital providers under Title XIX could maintain an action against the State of New York where the "State Plan" and state law were in conflict with Title XIX of the Social Security Act as amended.

It seems anomalous that the Federal Government should not allow judicial relief in a section of an area where most states do, and even where the Federal Government allows it in all other sections of the area.

In a procurement situation where the agency acts as legislator, prosecutor, judge and jury all combined, without any restraints except its own, arbitrary action is not discouraged.

Accordingly, we propose that direct suits against the Secretary be allowed to be brought in the United States District Court where the facility is located or in the United States District Court in the District of Columbia and where the amount of the claim is $10,000 or more and has been pending for 90 days. (See Appendix B., Section II for the suggested amendment to the Social Security Act.)

The present hospital and Post Hospital Extended Care Services benefit structure under Medicare has contributed to the problem of inappropriate use of institutional services. At the present time, after the patient pays the deductible, he is entitled to 60 days of hospital benefits covering all applicable charges without paying any further deductibles or coinsurance. After 60 days the patient pays the daily coinsurance until he has exhausted the hospital benefit of 90 days in a spell-of-illness. In addition, the patient is entitled to a lifetime benefit of another 60 days of hospital care. On the other hand, after only 20 days in an extended care facility the patient must pay a daily coinsurance until he has exhausted the extended care benefit of 100 days in a spell-of-illness. This situation encourages the patient, the physician and even the state (where the patient is on welfare and eligible for Medicare) to keep the patient in a hospital as long as possible. The often mentioned, retroactive denials of extended care benefits further encourages longer stays in hospitals.

This situation could be rectified in part by relating the number of "free" days in both hospitals and extended care facilities to average length of stay, but in no case allowing for more free hospital than free ECF days. The number of allowable hospital and ECF days should be limited to 50 rather than the present 90 and 100 days respectively. An additional 50 days can be allowed for a certified catastrophic illness. (See Appendix B., Sections III and IV for suggested amendments to the Social Security Act.)

Definition of "spell of illness"

Section 1861(a) defines "spell of illness" as commencing with the first day a patient enters a hospital, uses his hospital and/or extended care benefits, and ending 60 consecutive days thereafter, on which he is neither an in-patient in a hospital or an extended care facility.

An "extended care facility" for the purposes of "spell of illness" was defined by Congress in section 1861(j) (10) as a facility "which is primarily engaged in providing to in-patients (a) skilled nursing care and related services for patients who require medical or nursing care, or (b) rehabilitation services for the rehabilitation of the injured, disabled, or sick persons." Although Congress specifically defined an "extended care facility" for the purposes of "spell of illness," the Social Security Administration had radically altered the Congressional definition, in effect preventing many thousands of beneficiaries from ever ending a spell of illness, or really ever having a second coverage under Medicare.

The Social Security Administration has done this by defining an "extended care facility" as a facility which is under supervision of a licensed practical

nurse—who need not be a graduate of a State approved school—with aides, orderlies, or attendants on the other two shifts. One example will best illustrate the hardship. Patient A is a man 75-years-old and living in a custodial home, a typical retirement type home, of which we have many in this country. He can get around, but he needs someone to make sure that he eats his meals and takes his medicine. Patient A has a severe heart attack. He enters the hospital for 90 days. He is then transferred to an "extended care facility" for 100 days. He returns to the custodial home, the retirement home, his original point of origin, where he has lived for 2 years. He can never again become eligible for medicare benefits under letter No 65 because there is 8 hours a day of "nursing service" available in that retirement home. This residential care home is considered by the Social Security Administration to be an extended care facility solely for the purpose of not breaking his "spell of illness," or granting him another benefit period. In effect, if he falls down the stairs 6 months later and breaks a leg, it is just too bad. He is not possibly covered again under these conditions.

State agency letter No. 65 makes one's medicare benefits hinge on his station in life or on the circumstances under which he is living at the time he enters the hospital. The result is that the individual who needs medicare benefits the most is denied them. (See Appendix B., Sections V and VI for suggested amendments to the Social Security Act.)

RULE MAKING—HEARINGS ON THE RECORD

In general, rule making is a major aspect of the total governmental process. The fact that it is a function of the administration branch of government does not alter the fact that rules and regulations are law. Therefore, rule making should be effected through careful and deliberate consideration of the facts involved and responsible decisions of those facts. The enormity of the task requires some reasonable categorization under which less substantive rules may be adopted through a relatively simple process. Rule making involving more substantive factors such as property rights should require processes which provide greater opportunity for presentation of facts and a more formal record of the process. The rule making implementing the Medicare program has been less than satisfactory.

The record of the adoption of the rules on "reasonable cost" is an example. In almost every instance where the local, state or federal government files a rate, other than a negotiated rate, for which the government or the public has to pay for a service or commodity, the rate is required to be fixed after a public hearing on the record.

This is true in connection with public utility rates, railroad, bus and trucking rates, airline fares, stockyard rates and many others. In fact, it was the hearings on stockyard rates that produced the decisions of the United States Supreme Court in the four *Morgan Cases* which became the foundation for the Federal Administrative Procedure Act.

The Medicare Act does not require a hearing in connection with the development of the "reasonable cost" formula. It requires that it be reviewed by the Health Insurance Benefits Advisory Council. However, HIBAC avails itself of the HEW Staff and utilizes the HEW General Counsel's office for legal and other advice so that it is not wholly independent of the Secretary. When HIBAC made its recommendations for the first reasonable cost formula, it relied in part on the then General Counsel and staff who advised that the law did not allow a return on investment or cost of capitol factor for proprietary extended care facilities. This opinion was contrary to all professional legal and accounting advice including the opinion of the General Accounting Office later obtained by the Senate Finance Committee in a report dated May 24, 1966 and quoted in Appendix A hereto. The minutes of HIBAC were restricted and no one knows for certain what facts or factors HIBAC or the Secretary relied upon in approving the reasonable cost formula developed by the HEW staff members (the same staff members that advised HIBAC).

A large number of formulas for reimbursement by states under Title XIX require that the rate be fixed after notice and hearing. This is the only fair, reasonable and legal approach. Otherwise there is no reasonable opportunity to form a record on the basis of which a reasonable rate can be fixed. There is no adequate means of questioning the facts or factors (which are unknown) considered by the HEW staff in the rate which they recommend to the Secretary. This is contrary to American Administrative Law principles of fairness.

The American Nursing Home Association recommends that rule making on Section 1861 of the Social Security Act include adequate notice, opportunity for hearing and participation by providers and other affected parties. (See Appendix B, Section VII for a suggested amendment to the Social Security Act.)

APPENDIX A

I. REASONABLE COST REIMBURSEMENT

A. LEGISLATIVE HISTORY

The reasonable cost concept or formula which first came into being in the Medicare Act, Public Law 89–97, was enacted by the Congress in 1965. The term "reasonable cost" sounded so reasonable that no one in the health care field questioned the fact of whether reasonable cost was a proper concept for the entire field. All of the legislative history that was developed before the House Ways and Means Committee and the Senate Finance Committee was related solely to non-profit hospitals. There was no discussion in the legislative history before either of those Committees, or on the floor of the House or the Senate which gave any clue as to how reasonable costs would operate with regard to nursing homes, either proprietary or non-proprietary.[1] It was only after the decision of the Health Insurance Benefits Advisory Council (HIBAC) in late January of 1966 that (1) proprietary nursing homes under the Medicare Act would not be allowed any factor for return on investment, and that (2) a decision as to whether non-proprietary nursing homes under the Medicare Act would not be allowed any factor for return on investment, and that (2) a decision as to whether non-proprietary nursing homes would be allowed a growth factor was postponed a year, that anyone investigated the concept of "reasonable costs" to determine what was going on in the minds of those who had created this concept.

In March of 1966, after several discussions with various members of the House Ways and Means Committee, it was learned that during the consideration of the 1965 legislation, Congressman Broyhill of Virginia had questioned Commissioner Ball and then Undersecretary Wilbur Cohen as to how reasonable cost would be attractive enough to a proprietary institution to encourage it to participate in the Medicare program. The answer given by these gentlemen was that there was a certain vacancy rate that occurred in most proprietary institutions, and that these institutions consequently would be glad to take Medicare patients without any factor for return on their investment because in helping to fill these vacancies Medicare would help to decrease their overhead.

This is ridiculous reasoning and as later events have demonstrated that under the Medicare formula and regulations there are many costs which the Social Security Administration has not allowed. In addition, the care, especially nursing service and other ancillary services required by the Social Security Administration, normally is greater than that given to welfare patients or private paying patients. The cost of delivering the care to Medicare patients by a proprietary or non-proprietary nursing home is far in excess of that required by other patients.

This colloquy between Congressman Broyhill and Commissioner Ball is not a part of the legislative history since it was omitted from the printed hearings before the House Ways and Means Committee, as was much other material.[2] The nursing home field, as well as the hospital field, was completely misled as to what the concept of reasonable cost really meant. Section 1861(v)(1)(A) defining reasonable costs, provides that the cost of Medicare patients shall not be borne by the non-Medicare patients in the institution and vice versa, that the cost of care of non-Medicare patients will not be borne by the Medicare patients. This provision has worked in a very one-sided manner, as indicated later in this paper. Many of the costs of Medicare patients are being borne by

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[1] See the testimony of HEW Undersecretary Cohen, SSA Commissioner Ball, SSA Actuary Robert Myers, Mr. J. Henry Smith, Vice President of the Equitable Assurance Society of New York and that of Messrs. Morgan, Longbrey and Bucher of the Hospital Council of the National Capital area, on the question of reasonable costs before the House Ways and Means Committee, 89th Congress, 1st Session, Executive Session hearings on H.R. 1 and H.R. 7765; Vol. 1, p. 131–151, 416–417 and Vol. 2, p. 774–791. (January and February, 1965).

[2] Op. Cit. 1, page 1735 of the Stenographic transcript of Executive Hearings on H.R. 1, and H.R. 7765 which footnote 1 (above) refers to in the printed hearings.

non-Medicare patients, whereas the costs of non-Medicare patients are not being borne by the Medicare patients. The government, in many instances, is getting a free ride for part of the cost of its Medicare patients from both the proprietary and non-proprietary nursing homes.

B. CONSIDERATION OF IMPUTED INTEREST BY HIBAC

The Act requires that the regulations promulgated by the Secretary (Conditions of Participation), as well as the development of the reasonable cost formula be considered by HIBAC after consultation with national organizations and associations. HIBAC met for several months starting in early November, 1965, and continued for almost a year, in developing the Conditions of Participation including the reasonable cost formula. In this connection, most of the meetings during December and January, in whole or in part, as are reflected by the minutes, concerned what sort of a factor HIBAC was willing to recommend to the Secretary of Health, Education and Welfare as an allowance for return on investment in proprietary institutions and as a growth factor in non-proprietary institutions. HIBAC was advised by the General Counsel of Health, Education and Welfare that the reasonable cost formula set forth in Public Law 89–97 precluded any profit by a proprietary institution. His attitude was that reasonable costs were the bare costs of operation or administration of a health care facility which were reasonable. There is one sentence in the Senate Finance Committee report when taken out of context that gives some credence to this view. However, it seems not only unconscionable, but contrary to all the precedents in all other fields of procurement by the government that the providers of the service are not allowed a fair return on their investment.

Indeed, public utility corporations, even though monopolies and even though regulated, are allowed a fair return. Proprietary extended care facilities are the only instance where the government has precluded a fair return on investment.

Non-profit corporations, also, have to take in more than they pay out each year. Otherwise there is no allowance for growth or even maintaining the facility in its present condition. During the sessions of HIBAC in December of 1965 and January of 1966, they discussed many ways in which a return on investment could be allowed. One of the most frequently discussed method was the so-called imputed interest. A rough draft for discussion purpose before HIBAC dated January 1966 contains the following statement on page 19.

"c) *Return of earnings to owners*—Owners of proprietary extended care facilities are entitled to a fair return on investment. Patients and their third party sponsors are responsible for this financial need. Such needs should be included as a factor in a cost-based method of reimbursement. This need should perhaps be computed on the basis of a percent of return on total equity (investor's equity capital as well as borrowed funds). Interest costs incurred on borrowed capital, then, should not be allowed as an element of cost for reimbursement. A suggested amount to be included in a cost-based method of reimbursement should be a reasonable percentage above the commercial mortgage rate in a particular geographic location."

Mr. Robert Myers, then actuary for the Social Security Administration, testified on May 25, 1966 before the Senate Finance Committee that in the original cost estimates of the Medicare program which he furnished the House Ways and Means Committee in 1965, he had included an *imputed interest factor for proprietary nursing homes in lieu of profit.*[3]

Even before the adoption of the Miller Amendment, the General Accounting Office made it clear in its report of May 24, 1966 to the Senate Finance Committee, that the cost of capital was a cost factor which could be recognized under "reasonable costs." That report states, in part:

"For the profit institution the use of capital clearly represents a cost in the economic sense if not in the accounting sense. Without expectation of a return on capital it would not be dedicated to a particular use. *Indeed, it is normally the expectation of a return greater than that available through investment in risk-free securities that capital is funneled into any particular channel.* In a very real sense, the investor must regard the forebearance of the risk-free long-term interest available to him as a cost in terms of deciding whether to use his capital for a particular purpose. It is only with respect to the return he receives over and above risk-free interest available to him that he may be said to have profited in

[3] "Reimbursement Guidelines for Medicare", Hearing before the Committee on Finance, United States Senate, Eighty-Ninth Congress, Second Session, May 25, 1966.

the economic sense from his decision to utilize his capital for other than investment in securities. *Recognizing these fundamental concepts upon which private profit seeking capital is utilized, we would not question the legal authority of the Secretary to apply the cost principle in question in profit-making institution situations.*"

C. HEW REGULATION—CONDITIONS OF PARTICIPATION

The original Conditions of Participation for extended care facilities recommended by HIBAC and promulgated by the then Secretary, provided as a part of reasonable costs for reimbursement to both proprietary and non-proprietary facilities based on a 2% of the allowable costs, or 4.75% of net equity, whichever was lesser.[4] The 4.75% figure was selected by the HEW staff, ostensibly because it represented the current interest rate on the obligations issued for purchase by the Federal Hospital Insurance Trust Fund, but probably because it was very low. In fact, it had no relationship to the cost of money in the market to a nursing home owner at that or any other time.

Since these two factors were mutually self-limiting, and in effect, allowed no realistic amount for unrecognized and immeasurable costs (especially in the case of proprietary facilities) nursing homes throughout the country at first were reluctant to participate in the Medicare program.

D. EXTENDED CARE FACILITIES PARTICIPATED ONLY BECAUSE OF HOPE OF CONGRESSIONAL RELIEF

Members of the American Nursing Home Association (ANHA) joined the program principally because the association assured them that ANHA would make a supreme attempt to obtain some relief through legislation in Congress. It was recognized by the free-standing nursing homes (proprietary and non-proprietary) that many in HEW wanted only Federal or State nursing homes, and particularly wanted to eliminate proprietary and church affiliated non-profit nursing homes. As state above, the nursing home field had been lulled into a false sense of security because HIBAC had considered, and Mr. Robert Myers, the actuary for the Social Security Administration had also taken into consideration in his estimates to the House Ways and Means Committee, factors for a return on investment, among them, the concept of imputed interest.

E. THE 1966 MILLER AMENDMENT

In late 1966, ANHA sponsored the so-called "1966 Miller Amendment," the final version of which, as adopted by the Congress, was supposed to give a 7½% return on the invested equity in an extended care facility. The amendment, as originally drafted, provided for 7½% return on the appraised value of the extended care facility. This amendment was accepted unanimously by the Senate as an amendment to House passed Bill H.R. 6958, which allowed the filing on the original basis of income tax returns. Most of the senior members of the Senate Finance Committee spoke in favor of the amendment. In fact,[5] no member of the Senate Finance Committee or any other member of the Senate opposed the amendment on the floor of the Senate.

Since the Miller Amendment was an amendment to a House passed Bill, it was necessary that it go before a House-Senate Conference Committee on H.R. 6958. The Undersecretary appeared before the Conference Committee (of course, the ANHA had no representative before the Committee), and bitterly fought the Miller Amendment. He is reputed to have said that the amendment would cost upwards of two hundred fifty million dollars. This, of course, was inaccurate to say the least. The association had estimated that the original amendment would cost between $18,000,000 and $26,000,000.[6] The association took the position that by rewarding the proprietary and non-proprietary institutions to this extent, the government would receive far better health care at less cost per facility. The Conference Committee finally agreed on a 1½% factor for proprietary

[4] Conditions of Participation for Extended Care Facilities, U.S. Dept. of Health. Education and Welfare on June 1, 1966.

[5] See statement of Senators Long and Miller in Congressional Record of September 22, 1966. Senator Long stated that it had been discussed with the ranking Democratic committee member Senator Smathers and the following ranking Republican members, Senators Dirksen, Williams and Carlson all of whom approved the amendment.

[6] This estimate was based on a 7% return on the appraisal value of the number of ECFs that had been certified. During the 5 year period, 1961 through 1966, some 300,000 beds or half of the then 600,000 beds were constructed at a total cost of $1½ billions.

nursing homes because the Undersecretary represented to them that of the 2% given on allowable costs, ½% of 1% represented a recognition of the equity factor. Of course, this was not true because this 2% allowance was restricted by the factor of 4.75% of the net equity, whichever was lesser. Senator Carlson and other members of the Conference Committee strongly urged an additional growth factor for non-profit nursing homes.[7] As a compromise, non-profit extended care facilities were given the full 2% allowance, rather than the 2% allowable costs or 4.75% net equity, whichever is less, as before.

F. HEW PLAYED FAST AND LOOSE WITH THE COMMITTEE

The Conference Committee requested the Undersecretary to have language drafted to carry out the consensus of the Committee. Secretary Cohen submitted the language the next day which limited 1½% by 7½% of net equity (in addition to the straight 7½% of net equity). This sounds rather complicated, but Secretary Cohen was attempting to go back to the formula devised by HIBAC and the HEW staff which limited the 2% allowance costs by a net equity factor. The Conferees immediately turned it down as contrary to their agreement. Language finally was drafted by the staffs of the House Ways and Means Committee and the Senate Finance Committee.[8]

However, when Secretary Cohen implemented the language agreed upon by the House-Senate Conferees and adopted by the House and by the Senate, and signed by the President, he defined "equity" as an equity that was a depreciated equity. This was contrary to the understanding of the Conferees. Likewise, it was contrary to the understanding which Mr. Robert Myers, the Social Security Administration actuary, had of the term "equity". In the language agreed to by the House-Senate Conferees and adopted by the House and later by the Senate, equity was defined only to the extent that it was to include "working capital" as well as "prepaid expenses". In other words, under the regulations issued by the Undersecretary, an extended care facility having, for example, 100 beds and costing $1,000,000 (assuming it was paid for in 20 years, at the end of 20 years, or if it were 20 years old now) the owners would have no equity, so it would be 7½% of nothing.

On the other hand, assuming the first year that the owners had an equity of $50,000, and for tax purposes they had depreciated their $1,000,000 investments $50,000, their net equity would be zero. The payment would be 7½% of the percentage of Medicare patients (ranging from 5% to 25%) of zero or zero. Likewise, at any point along the line, when SSA pays a percentage on depreciated equity it pays a percentage on almost next to nothing. Under the definition, working capital and prepaid expenses had to be taken into account so the formula really amounted to 7½% of prepaid expenses, working capital and no equity or next to no equity.

Only extended care facilities initially included

Even though the Miller Amendment was limited to extended care facilities solely, the other associations deluged the House-Senate Conferees with telegrams and exerted intense pressure on the Conference Committee and particularly on HEW. This resulted in Secretary Cohen recommending that he should give them similar treatment administratively. Consequently, the report of the House Conferees recommended issuing the regulations with the Secretary providing a like amount to proprietary hospitals.[9] When the regulations were issued,

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[7] Statement of Senator Carlson at p. 26568 of the October 19, 1966 Daily Congressional Record.

[8] "Section 1861(v)(1) of the Social Security Act is amended by adding at the end thereof the following new sentences: 'Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.' "

[9] See Report of House Conference on H.R. 6983, H.R. 2317, 90th Cong. 1 st Sess., dated Oct. 18, 1967 reprinted in the Daily Congressional Record of Oct. 19, 1967 at p. 26036.

The statement on the report of the House conferees is as follows:

"The managers on the part of the House at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 6958) to amend the Internal Revenue Code of 1954 to promote savings under the Internal Revenue Service's automatic

both proprietary and non-profit hospitals were included. Those that really benefited most from the 1966 Miller Amendment were the non-proprietary extended care facilities and hospitals. They received a straight 2% of allowable costs, whereas proprietary institutions received only a 1½% because, as stated above, Under Secretary Cohen represented that ½% of the 2% was for return on investment.

G. REIMBURSEMENT HEARINGS OF MAY 25, 1966

It is doubtful that the House-Senate Conferees intended that the full 2% be given to non-profit hospitals. The amendment before the Conference Committee related only to extended care facilities. The report of the House Conferees referred only to extended care facilities, except that there is one mention of "proprietary hospitals".[10]

This is further borne out by the hearing before the Senate Finance Committee on May 25, 1966 in regard to "Reimbursement Guidelines for Medicare".[11] Many members of the Committee, among them Senators Anderson and Long who had been on the House-Senate Conference Committee on H.R. 6958 as amended by the 1966 Miller Amendment, took Secretary Cohen and Commissioner Ball to task for allowing the full 2% factor to nonprofit hospitals. Several other Senators joined them. All of these members of the Senate Finance Committee seemed to take the position that nonprofit hospitals were constructed by funds supplied by the federal, state and local governments and funds raised through citizen or community efforts, or were donations from other private sources, and, therefore, the Federal government should not give any factor for growth on these or other public funds or for similar funds for capital improvements and the 2% factor was actually a "sweetner" for hospitals.

H. ANHA POSITION ON ELIMINATION OF THE 1 PERCENT AND 2 PERCENT

It is the position of the association that the 7½% as well as the 1½% allowance on allowable costs for proprietary institutions and the 2% on nonproprietary institutions stands on a far firmer footing than the 2% allowance for nonprofit hospitals. The 7½% and the 1½% are not the result of solely regulations by the Secretary. However, they are the result of the agreement reached between the House-Senate Conference of Health, Education and Welfare, and it seems inconceivable that the Secretary could issue a regulation eliminating these factors when his predecessor had an agreement with the House-Senate Committee on which both the Senate and House acted in adopting H.R. 6958.

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data processing system, submit the following statement in explanation of the effect of the action agreed upon by the conferees and recommended in the accompanying conference report:

The Senate amendment added a new section 7 to the bill as passed by the House. Under the amendment, section 1861(v) of the Social Security Act (which relates to the determination of reasonable cost of services for purposes of title XVIII of such Act) would have been amended by inserting a new paragraph (2) providing that "reasonable costs" for extended care facilities are to include a return on the fair market value of the facility sufficient to attract capital investment. In determining reasonable costs under section 1861(v), the Secretary of Health, Education, and Welfare was directed to consider, among other things, certain specified factors.

The House recedes with an amendment which is a substitute for the Senate amendment. The conference substitute requires that regulations under the health insurance program relating to the reasonable cost of extended care services furnished by any proprietary facility specifically recognize a reasonable return on equity capital invested in the facility (or portion of the facility) used for the furnishing of the services. Such equity capital is to include any necessary working capital so invested. The rate of return so recognized for any fiscal period may not, however, in the case of any proprietary facility exceed 1½ times the average rate of interest on obligations issued for purchase by the Federal hospital insurance trust fund during the fiscal period. Such average rate is to be computed by taking the average of the rates of interest for each of the months any part of which was included in that period.

It is expected that in recognition of this amendment the 2 percent of operating costs which would be allowed, in lieu of specific allowances for "other costs", under the proposed regulations of the Secretary of Health, Education, and Welfare will in the case of extended care services provided by proprietary facilities be reduced by one-fourth, to a total of 1½ percent of the operating costs.

The conferees expect that the Secretary of Health, Education, and Welfare will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them."

Signed: W. D. Mills, Cecil R. King, Hale Boggs, Eugene J. Keogh, John W. Byrnes, Thos. B. Curtis and James B. Utt, Managers on the Part of the House.

[10] Ibid., p. 26636.

Appendix B

ANHA's Proposed Amendments To Title XVIII of the Social Security Act As Amended

(Public Law 89-97 as amended)

I. Amend Section 402[1] of the Social Security Act as amended to give the Secretary broader authority to experiment with true incentive plans in connection with the reimbursement of extended care facilities by adding a new Section 402(d) at the end of Section 402(c), striking out the period and inserting a comma and the word "or."

"(4) Under a plan developed under Title XVIII or Title XIX of such Act, and which are selected by the Secretary in accordance with regulations established by the Secretary, could be reimbursed or paid in any manner mutually agreed upon by the Secretary and the extended care facility."

"The method of payment of reimbursement to post hospital extended care facilities, whether on the basis of a state, region, fiscal intermediary or facility or a portion thereof,[1] which may be applied in such experiments shall be such as the Secretary may select and may be based on charges, costs, a flat rate or a negotiated rate, or any other concept, adjusted by incentive factors, which may reward the provider by sharing the savings of costs or projected cost, increases or projected increases of costs or by the payment of a fixed fee or some other method and may include specific incentive payments or reduction of payments for the performance of specific actions but in any case shall be such as he determines may, through experiment, be demonstrated to have the effect of increasing the efficiency and economy, or either, of health services through the creation of additional incentives to these ends without adversely affecting the quality of such services."

II. Amend Section 205 of the Act to allow providers of service to sue the government directly for claims in excess of $10,000 by adding a new subparagraph to Section 205(h) as follows:

"(h) Notwithstanding any other provisions in this title, any provider of services whose claims, directly or indirectly, under any section of Title XVIII (whether it be for benefits denied any individual under Part A or Part B for which such provider has furnished care or services or for other reimbursement, including but not limited to the cost of administering such title or both) aggregates $10,000 provided such claim has remained unpaid by the fiscal intermediary or by the Secretary for a period of ninety (90) days shall be entitled to bring an action against the Secretary under Section 1331 of Title 28 of the Judicial Code of the United States without further exhausting available administrative remedies, for damages or injunctive relief, in the United States District Court in any district in the State in which the provider of services is located, or the United States District Court for the District of Columbia, and service of process on a Regional Director of the Department of Health, Education, and Welfare shall be considered service on the Secretary."

III. Amend Section 1812 (a)(1) and (2) regarding "Scope of Benefits" to reduce hospital days and extended care days to 50 days and to read as follows:

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

"(1) inpatient hospital services for up to 50 days during any spell of illness,

"(2) post-hospital extended care services for up to 50 days during any spell of illness."

IV. Amend Section 1812 to provide for an additional 50 days of hospital or extended care for catastrophic illness or new diagnosis by adding a new paragraph (g) to read as follows:

"1812(g) Notwithstanding any other provisions of this title, inpatient hospital services for up to an additional 50 days and post-hospital extended care services for up to an additional 50 days shall be allowed for a catastrophic illness or for a new diagnosis that developed or was discovered for the first time in the hospital or extended care facility provided such a finding has been

[1] Technically, the underlined part is an amendment to 42 U.S.C., Sec. 1395(b)(1)(a). This paragraph (as unamended) was enacted as a part of the Social Security Amendments of 1967 (Public Law 90-248, Title IV, Sec. 402(a) and not as a part of the Social Security Act.

made or confirmed by the physician members of the Committee or group, as described in Section 1861 (k)."

V. Amend Section 1861 (a) (2) in regard to "Spell of Illness" to require a 90-day period in which they were neither an inpatient in a hospital or extended care facility and giving the term "extended care facility" the same meaning as it has in the remainder of the Medicare Act.

"(2) ending with the close of the first period of *90 consecutive* days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility under *Title XVIII*.

(b) Amend the last paragraph of section 1861(j) by deleting the phrase in parenthesis and the sentence after subparagraph (10) as follows: "(other than for the purposes of section (2) (2).)" "For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection."

VI. Amend Section 1862(a) to provide for a further definition of custodial care by Congress by adding the following to Section 1862(a)(9) and the following new subsection 1862(a)(13) to read as follows:

"1862(a)(9) Where such expenses are for custodial care. However, the first 10 days in an extended care facility are not to be considered custodial care, and in any event, the term, "custodial care" does not constitute any of the following: (1) observation an assessment of total needs of the patient or (2) planning, organization and management of a treatment plan or (3) rendering of direct services to a patient where the ability to provide the services requires specialized training or (4) in the case of psychiatric disorders that are primarily organic and neurological in origin."

"1862(a)(13) where the only service rendered in the hospital is skilled nursing care and/or some other service that can be rendered in an extended care facility."

VII. Amend Section 1871 of the Act by adding the following paragraph thereto:

"Notwithstanding any other provisions of the Act, rules and regulations promulgated by the Secretary pursuant to the provisions of Section 1861 shall not become effective unless and until adequate notice, opportunity for bearing and participation by providers or other affected parties is provided."

Senator ANDERSON. Governor Mandel.

Governor MANDEL. Senator, good morning.

Senator ANDERSON. We appreciate your being here this morning. Thank you very much for coming.

STATEMENT OF HON. MARVIN MANDEL, GOVERNOR, STATE OF MARYLAND; ACCOMPANIED BY DR. NEIL SOLOMON, SECRETARY OF HEALTH, AND DR. EDMOND ROUNER, EXECUTIVE ASSISTANT, STATE OF MARYLAND

Governor MANDEL. I appreciate the opportunity, Senator. I have a prepared statement which I will ask to be made part of the record. I am not going to take your time to read the whole prepared statement, but I would like to have it made part of the record.

Senator ANDERSON. Without objection it will be done.

Governor MANDEL. I will give a copy of it to the reporter.

Senator ANDERSON. Thank you.

Governor MANDEL. I also have with me Dr. Neil Solomon, who is the secretary of health of Maryland. In the event there are any questions that you would like to propound to him he will be available for any questions from the committee.

Senator ANDERSON. Thank you.

Governor MANDEL. I, of course, am representing this morning the National Governors' Conference. I am a member of the executive

committee, and have been asked to state the views of the National Governors' Conference on the provisions of H.R. 17550.

As I said earlier, rather than reading the entire statement to you, I would like to get into what I think are the pertinent aspects, and explain the position of the Governors' Conference on these aspects.

I will stress two of the major points.

One, the Governors' opposition to provisions in the bill which reduce Federal participation in the cost of long-term care under medicaid.

Second, there is a need to concentrate Federal and State efforts on further refinement of the present cost control provisions and administrative procedures for medicaid in the present law before further major changes are made in the medicaid program itself.

It appears that in the bill the House Ways and Means Committee used two general approaches to solving some of the Federal problems related to the cost of medicaid. They were:

1. Provide financial incentives to improve the administration and cost control procedures in the State administration of medicaid.
2. Shift part of the unanticipated costs of the medicaid program from Federal to State government by reducing Federal participation in the cost of services.

There were at the 1969 and the 1970 meetings of the National Governors' Conference, policy statements made at those two conferences, directed towards the medicaid program.

This year, at the last meeting, in direct response to H.R. 17550, the following statement was made, and I would like to read that statement to you, sir:

> We support restoration of proposed cuts in Federal funds for the medicaid program or assurance that steps will be taken to insure that these cuts are not merely passed back to State and local governments in the form of increased expenditures or result in reduced services for recipients.

The provisions in the bill of the most concern to the Governors are the proposal to reduce the Federal matching for long-term care. I do not feel that the limitation in Federal participation after the 90th day in skilled nursing homes is at all realistic. Many of the patients certified for skilled nursing home care cannot be cared for in any other type facility after the 90th day.

I further feel that the imposition of this limitation on Federal matching would be an act of bad faith by the Federal Government toward those States which have a skilled nursing home program under title XIX.

Likewise, many chronically ill patients require special services and attention, and the Federal Government should continue to accept part of the responsibility for the care of the mentally ill as they do under the present law.

In the House bill report accompanying the bill, it was stated that the reduction in matching for skilled nursing home care, as proposed in the legislation, is directed toward early transfer of the patients to alternate facilities, such as intermediate care facilities.

The report goes on to state that these provisions reflect the problem that many patients remain in skilled nursing homes longer than nec-

essary, and that, as a result, program costs are unnecessarily increasing. This, I think, is probably true and is a realistic statement.

However, and we would be the first to admit, in the early stages of the program this was the situation. But now, just as the Federal Government is increasing its skill and learning how to operate under the medicaid program, and to control the costs and administration, so the States are improving their efforts to control and eliminate the overutilization of skilled nursing homes.

For example, in the State of Maryland this past year, steps have been taken to match the level of care with the individual's needs. In conformance with Federal regulations, onsite medical reviews of patients in skilled nursing homes were conducted. Also procedures have been developed to review more adequately all patients applying for skilled nursing home care under the medicaid program to determine if they need that level of care.

It should be pointed out, too, that having the Federal requirements that patients now in skilled nursing homes do not need that level of care should be transferred to intermediate level care, does not automatically create the facility necessary for that care.

In other words, we may not have the facilities to move the people from the skilled nursing home care to the intermediate level care.

Another Maryland example of assessing suitable care is the use of a geriatric evaluation service at Good Samaritan Hospital in Maryland. It screens out those people who are not able to care for themselves properly but who do not belong in mental hospitals.

Before the advent of the geriatric evaluation service, many confused and needy elderly people were committed to mental hospitals. Under the new program individuals are screened to determine the level of care they need unless hospitalization in a mental hospital is clearly required.

If they are not required, arrangements are made for care at other institutions or in their own homes.

Now, I know that time is an important factor here, but I would just like to add these few remarks and read to you the conclusion that we feel is essential to any approach taken to the medicaid program.

The cost of the medicaid program was grossly underestimated prior to its initial enactment. The unanticipated high costs resulted from (*a*) increases in wages to health service personnel; (*b*) the unanticipated health care needs of the poor and the high rate of use of health services by those covered under medicaid; and, (*c*) problems in administration resulting from both Federal and State inexperience and lack of adequate procedures to administer medicaid.

2. It has just been during the past year that final regulations have been published by the Federal Government for implementing many of the provisions of the 1967 amendments to medicaid. Therefore, their impact is just beginning to be felt.

3. There will be a timelag between the provision of financial incentives for the use of a certain type of health care and the actual availability of the new mode of care.

I think, more important, there is now, I think, an abundance of evidence during the past year that States are bringing overutilization under control, and improved State administrative procedures are being developed for medicaid.

Therefore, my suggestion on behalf of the Governors' Conference to this committee is that, before major changes are made, Congress first allow time for the refinement of the cost control provisions and administrative procedures for medicaid already required under existing law. Such refinement would not be assisted by arbitrary cuts in Federal matching or by many other changes in Federal law and regulations which would cause instability and disruption in the administration of medicaid which is now being refined by States.

I think the big point we would like to make, Senator, is that there has been a great deal of confusion in the program: confusion resulting from both sides of the picture: Federal and State; (1) from regulations not being published; (2) from States not having complete control over the program, however, these problems are now being worked out within the individual States. We are getting much greater control and better programs. We are becoming able to improve supervision. We are establishing more effective cost control, far more effectively than during the last few years.

In our own State, a year and a half ago we had a $5 million deficit in the program. As of the end of this fiscal year we have eliminated the deficit, and we have had a surplus in the program because the costs have been reduced by putting into effect cost control supervision under the secretary of health. He has managed to control the costs and managed to supervise the program to where we are reducing the costs of the program.

What we feel is that if chasnges are made now that result in our having to go and review again our procedures we are just going to have additional confusion that is again going to set the program back.

I do not want to take any more of your time unless there are any questions.

(The prepared statement of Governor Mandel follows:)

STATEMENT BY HON. MARVIN MANDEL, GOVERNOR OF MARYLAND

Mr. Chairman, members of the Committee, I appreciate the opportunity to appear before you to discuss H.R. 17550, the Social Security Amendments of 1970. I will confine my remarks to those parts of the legislation relating to Medicaid and specifically, those provisions in H.R. 17550 having significant impact on state Medicaid programs.

In my testimony today I am presenting the policy statements of the National Governors' Conference of which I am a member of the Executive Committee. In addition, I will be giving my own views specifically related to our experience in the State of Maryland with the Medicaid program.

I would also like to request that letters and other materials on H.R. 17550 which have been provided by Governors to the Washington Office of the National Governors' Conference be included in the hearing record.*

As this committee is aware, the Medicaid program is of serious concern to Governors, not only because of its cost but also because of the desire of Governors to provide sufficient and adequate health care for the needy citizens of their States.

Governors have the responsibility, as does the Senate Finance Committee, of not only designing service programs in the health and welfare area to meet human needs but also designing tax programs to finance such governmental services. We as Governors are keenly aware of the difficult problem that this committee faces in attempting to control the ever-mounting costs of the Medicare and Medicaid programs with some States requiring up to 20 percent of their budget to cover the costs of the Medicaid program in the State.

*The material was made [illegible] rt of the official files of the committee.

My testimony today will stress two major points:

1. Governors' opposition to provisions in H.R. 17550 which reduce federal participation in the cost of long-term care under Medicaid.

2. There is a need to concentrate federal and state efforts on further refinement of the present cost control provisions and administrative procedures for Medicaid in present law before further major changes are made in the Medicaid program itself.

It appears that in H.R. 17550 the House Ways and Means Committee used two general approaches to solving some of the federal problems related to the cost of Medicaid. They were:

1. Provide financial incentives to improve the administration and cost control procedures in the state administration of Medicaid.

2. Shift part of the unanticipated costs of the Medicaid program from federal to state government by reducing federal participation in the cost of services.

Of course, only the first of these two approaches for dealing with the joint federal-state problem of the rising cost of Medicaid is acceptable to Governors.

NATIONAL GOVERNORS' CONFERENCE POLICY STATEMENTS

At the 1969 and 1970 Annual Meetings of the National Governors' Conference policy statements related to the Medicaid program were adopted. The Governors approved the following policy statement on national universal health insurance and its relation to Medicaid:

"Adoption by the Federal Government of a national universal health insurance program coupled with hospital cost controls as the primary method of keeping rising health costs from preventing all people from receiving the medical care they need. Such a program should utilize the existing private enterprise medical system. Publicly paid programs such as Medicaid should be used only as a secondary program for those who have used up their insurance benefits. Medicaid should be 100 percent federally financed."

This year in direct response to H.R. 17550, the Social Security Amendments of 1970, the following policy statement was also adopted:

"We support restoration of proposed cuts in federal funds for the Medicaid program or assurance that steps will be taken to insure that these cuts are not merely passed back to state and local governments in the form of increased expenditures or result in reduced services for recipients."

In recognition of the particular problems of Puerto Rico, the following policy statement was also adopted:

"Removal of ceilings on the amount of federal expenditures for Medicaid in Puerto Rico."

Proposed reduction in Federal matching for long-term care

The provision in H.R. 17550 of the most concern to Governors is the proposal to reduce federal matching for long-term care. I do not feel that the limitation in federal participation after the 90th day in skilled nursing homes is at all realistic. Many of the patients certified for skilled nursing home care cannot be cared for in any other type facility after the 90th day. I further feel that the imposition of this limitation on federal matching would be an act of bad faith by the Federal Government toward those States which have a skilled nursing home program under Title 19.

Likewise, many chronically ill patients require special services and attention and the Federal Government should continue to accept part of the responsibility for the care of the mentally ill as under the present law. In the House bill report accompanying HR 17550, it was stated that the reduction in matching for skilled nursing home care, as proposed in the legislation, is directed toward early transfer of patients to alternative facilities such as intermediate care facilities. The report goes on to state these provisions reflect the problem that many patients remain in skilled nursing homes longer than necessary and that as a result program costs are unnecessarily increasing.

It must be admitted that during the early stages of implementing the Medicaid program, this may have been the situation. However, just as the Federal Government is increasing its skills in the administration and control of costs in the Medicare and Medicaid programs so States are improving their efforts to control and eliminate overutilization of skilled nursing homes.

For example, in the State of Maryland during the past year effective steps have been taken to match the level of care with the individual's needs. In conformance with federal regulations, on-site medical reviews of patients in skilled

nursing homes are being conducted. Also, procedures have been developed to review more adequately all patients applying for skilled nursing home care under the Medicaid program to determine if they need that level of care. It should be pointed out, however, that having the federal requirements that patients now in skilled nursing homes who do not need that level of care should be transferred to intermediate care facilities does not automatically create that new facility. However, we believe that measures are now in effect in the State of Maryland to match patients' needs with a level of care.

Another Maryland example of assessing suitable care is the use of a geriatric evaluation service at the Good Samaritan Hospital in Baltimore.

The geriatric evaluation service screens out those confused elderly people who are not able to care for themselves properly but who do not belong in mental hospitals. Before the advent of the geriatric evaluation service many confused and needy elderly people were committed to mental hospitals. Under the new program individuals are screened to determine the level of care they need unless hospitalization in a mental hospital is clearly required. Arrangements are made for care at another institution or in their own home.

OTHER MEANS TO CONTROL MEDICAID COSTS

I would also like to indicate my support for two of the provisions in HR 17550 that, in effect, provide States additional means to control health care costs. These provisions are:

1. Reimbursement through Medicare and Medicaid would not be available for health facility capital costs not consistent with state or local health facility plans.

This provision is complementary to a recently enacted Maryland state law which relates comprehensive health planning activities to the planning, construction and licensing of health facilities including changes in the health services to be provided in the community.

2. States would be allowed to determine "reasonable costs" for in-patient hospital care and not be tied to the Medicare reimbursement formula which does not include incentives for efficiency and cost control.

CONCLUSION

In conclusion I would like to review the development of the Medicaid program which leads to a suggestion as to an approach to facilitate federal-state efforts to improve the administration of Medicaid.

1. The cost of the Medicaid program was grossly underestimated prior to its initial enactment. The unanticipated high costs resulted from (a) increases in wages to health service personnel; (b) the unanticipated health care needs of the poor and the high rate of use of health services by those covered under Medicaid; and, (c) problems in administration resulting from both federal and state inexperience and lack of adequate procedures to administer Medicaid.

2. It has just been during the past year that final regulations have been published by the Federal Government for implementing many of the provisions of the 1967 amendments to Medicaid. Therefore, their impact is just beginning to be felt.

3. There will a time lag between the provision of financial incentives for the use of a certain type of health care and the actual availability of the new mode of care.

4. There is an abundance of evidence during the past year that States are bringing overutilization under control and improved state administrative procedures are being developed for Medicaid.

5. Therefore, my suggestion to this committee is that before further major changes are made, Congress first allow time for the refinement of the cost control provisions and administrative procedures for Medicaid already required under existing law. Such refinement would not be assisted by arbitrary cuts in federal matching or by many other changes in federal law and regulations which would cause instability and disruption in the administration of Medicaid which is now being refined by States.

I want to thank this committee for the opportunity to appear before you to discuss the Medicaid program.

Senator ANDERSON. Thank you, Governor, for your statement.

Governor MANDEL. Thank you.

Senator ANDERSON. Dr. Kinmey.

STATEMENT OF DR. JAMES R. KIMMEY, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. KIMMEY. Mr. Chairman, I am Dr. James R. Kimmey, executive director of the American Public Health Association, a national organization of 25,000 professional workers and consumers dedicated to improving the health of the public. As individuals and as an organization, we are committed to the concept that health is a basic human right, and to securing programs that will make that concept a reality. Since personal health services—preventive, therapeutic, and rehabilitative—are an essential component of good health, the APHA has a deep and sustained interest in the medicare and medicaid programs.

We have made representations here in the past expressing our support for these programs, and offering suggestions we felt would substantially improve them. To our dismay, the recommendations have too often not found favor. In general, the experience to date with these programs has highlighted the deficiencies we had delineated, and we are glad to see Congress is now amending the authority to correct some of these deficiencies.

We have prepared extensive point-by-point comments on the provisions of H.R. 17550, and I would offer them for inclusion in the record if that is all right, and make a summary statement relating to the four main topics that we cover.

Senator ANDERSON. It will be received for the record.

Dr. KIMMEY. The four topics I am interested in speaking for a moment about are planning for improved facilities and services, utilization review, specific delivery proposals, and false economics.

Several of the provisions of H.R. 17550 are concerned with planning functions and practices—both institutional and communitywide. It is now widely recognized that an improved national planning mechanism is required if we are to bring about effective changes in the health care structure and begin to bring quality services to all our citizens. The comprehensive health planning legislation of 1966 created a legislative base for development of a system of regional and State health planning bodies. It gave these bodies a broad mandate to plan, but little authority to secure implementation of their plans. Thus it followed the pattern developed earlier in the voluntary areawide facilities planning movement. The health planning legislation was silent, however, on the matter of institutional planning. Clearly, the type of planning required if we are to begin to meet the needs of the public and solve the present deficiencies in the health care delivery structure—much less the demand that will result if something like the much discussed universal health insurance is enacted—involves interrelated planning activities at the institutional, areawide, State, and national levels.

We were pleased, therefore, when H.R. 17550 approached the problems of interrelated planning. Section 231 requires development of budget and capital expenditure plans by institutions designated as providers under medicare. Although this is desirable and we support the concept, to what end is it directed? There is no provision in section 231 for these plans, once prepared, to be reviewed. There is no linkage established between the institution's planning and that of the community or the State. If this provision is enacted, Congress

should clearly express its intent that the plans produced should be useful to the overall health planning effort.

If the planning to be used is the health planning agency, and we believe it should be, provision should be made for supporting the staff costs of review, either from fees to the reviewing agency or from Federal funds. To do otherwise might seriously impair the planning agencies' broader functions by imposing a heavy review load on their limited resources.

We also support the requirements of section 221 which would tie reimbursement for capital expenditures to consistency with areawide and State health planning. Concern with wasteful duplication of expensive facilities provided the initial impetus for development of voluntary areawide facilities planning. With the increasing commitment of public funds to health care, an increased public concern with the way in which these funds are expended is clearly justified. We have concerns, however, for the way in which the review procedure will be established. If the authority to review is vested in the State agency created under section 314(a) of the PHS Act, many such agencies will have to reorient their programs and staffing patterns. The flexibility given to the States in Public Law 89-749 in the creation of the 314(a) agency has resulted in great variability in the placement of such agencies in State government, their staffing patterns, and their degree of representativeness of the many health interests in the State. Areawide agencies, on the other hand, are already involved in similar functions in many areas of the country. Provision should be made for the State agency to delegate its functions under this section to areawide health planning groups if it chooses.

UTILIZATION REVIEW

Development of workable controls over the effectiveness of health care programs goes hand-in-hand with planning as a tool for achieving overall improvement in the quality of and costs of services. Although we are not impressed by the results achieved through utilization review procedures under title XVIII, we feel that the efforts should be continued and expanded further. It seems logical—if not imperative—that the results of utilization review become a part of the public record, and be a part of the input to the community health planning process. It should be noted here that although we favor participation of the broadest spectrum of professional interest in the review process, and feel that strong representation of practicing physicians—the "gatekeepers" of the institutional care system—should be maintained, we are opposed to placing the primary responsibility for such reviews exclusively in the hands of nonpublic professional organizations at any level.

SPECIFIC DELIVERY SYSTEM PROPOSALS

We would like to stress our interest in, and support for, the Health Maintenance Organization concept as embodied in H.R. 17550. It seems unfortunate, however, that prevention—certainly equally a part of health maintenance with therapy—has received short shrift in this proposal. Congress should make clear its intent that the HMO have a strong preventive medicine component.

Further comments are indicated in specifics of the HMO proposal. As valuable as the concept may be, the current proposal offers little incentive to providers to launch an HMO. The initial investment in such undertakings require "front-end" money, and the legislation should provide for developmental funding. One possibility would be a time-limited, 100 percent per capita cost allowance in the initial phases of HMO development as recommended by the medicaid task force. Another would be creation of a special funding authority to support startup costs, with such funds to be distributed in accord with approved areawide plans. If this innovative proposal is to be fully tested, the matter of incentive must be covered.

Finally, we hope the committee will pay particular attention to the development of effective monitoring and surveillance for the HMO program. This is an important demonstration of a new approach, and we must develop and maintain adequate quality controls, and assume that no abuses arising from underutilization, or from selection of good-risk patients only, prejudice the results.

FALSE ECONOMIES

Finally, we feel impelled to point out two provisions in H.R. 17550 which give the appearance of contributing to cost control, when in reality they have the potential of shifting costs from the Federal Government to the State or the consumer.

Section 223 deals with limitations on coverage of costs, but in the end contributes nothing to efficiency, since the excess costs of inefficient operations are simply passed on to the beneficiary. The Federal Government saves; the beneficiary pays.

Section 224 purports to control costs through limits on prevailing charge levels. In our view, this is based on the fallacious concept that there is something called a "prevailing charge" when in fact this has not been proved. The effect is again to pass costs on to the consumer while giving the appearance of a savings to government.

These brief comments highlight our views, and I would be happy to answer any questions you might have at this time.

(Material referred to by Dr. Kimmey. Hearing continues on p. 713.)

SECTION-BY-SECTION COMMENTS

COVERAGE UNDER MEDICARE PROGRAM

The amendments recognized the undesirable effects of the fact that certain needy groups in our population were omitted from the original Medicare coverage. Because Medicare is or should be intended to provide universal coverage for all persons 65 years of age and over, wives who have not been employed under covered employment, women unable to be insured on their own account, and those persons whose wages were so low or whose work was so sporadic as to deny them coverage under the existing program should certainly be brought into it fully. In all instances, the beneficiary should not be required to pay premiums for the hospital insurance, which is accorded to other Medicare beneficiaries as a matter of right. These heretofore uninsured people should receive medical benefits on the same basis as other beneficiaries, with the cost of such benefit met either through general tax funds or by setting aside a portion of the social insurance fund.

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

The APHA supports fully the principle embodied in this Section of H.R. 17550. Just as there is every reason to support necessary capital expenditures needed to provide health services, so too it is most unwise, if not fiscally immoral, to sup-

port capital expenditures for unneeded duplicatory health facilities. Overall planning for the total health system is imperative if we are to even approach cost controls. No new facility should be constructed, unless a need therefore can be demonstrated to the responsible public planning agencies. This is an important necessary step towards efficiency in operation of our health services system.

The mechanics proposed, however, should be carefully considered. It is highly dependent on the ability of the designated State planning agency to perform functions that would be almost totally new, and not entirely consistent with the missions undertaken to date by State health planning agencies funded under Section 314(a) of the PHS Act. Considering the current state of development of the agencies in the 54 jurisdictions, caution should be exercised in shifting their focus from broad consensus planning to facilities regulatory planning lest this dilute their primary mission.

PROSPECTIVE REIMBURSEMENT, EXPERIMENTS AND DEMONSTRATION PROJECTS

The APHA is in accord with this concept. As stated in the House Committee report, so long as reimbursement is based upon "reasonable costs," there is little, if any, incentive for greater efficiency. We would suggest that prospective reimbursement take regional cost comparisons into account and the cost of goods and non-physician services be differentiated from fees for physicians' services. Care should be exercised, however, in relation to the experiments with incentives. The quality of care delivered must not suffer. The uses to which excess of reimbursement over costs may be put should be specified. It is our understanding that some experience in respect to the incentive principle is currently available, and we would urge the Committee to study it carefully in order to avoid unfortunate consequences. We would particularly urge this Committee that ". . . recognized specialists in the health care field who are qualified and competent to evaluate the feasibility of any given experiment or demonstration project . . ." would be required to approve any such project.

STRENGTHENING AND EXTENSION OF THE UTILIZATION REVIEW PROCEDURE

We strongly support the proposed authority for areawide or community wide utilization review and its extension to Medicaid. It is our view that far less than the potential has been realized relative to current utilization review requirements and any strengthening of this element would be welcome. The findings of these reviews can provide crucial evidence needed to improve the efficiency of the local community health services system.

LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAMS

It is with mixed emotions that the APHA opposes Section 223 of H.R. 17550. While we agree that cost limitations are unquestionably in order, we believe this approach endangers the objectives of Medicare. You must not succumb to the temptation to reduce the level of health care under the Medicare program to the lowest common denominator. While we are sympathetic to the Congressional task of regulating a nationwide program, we must enter a protest against rigid reliance upon a fiduciary standard only. This instance affords an ideal opportunity to point out, as we have in the past, that the Medicare program has too little in it which sets up and protects a high standard of health service. There are gradations of health need which simply cannot accommodate to a "lowest common denominator." The example used in the House Committee report (pp. 31–32) is an oversimplification. At best, it does not address itself to the variations in health care which we believe must be considered. While it seems appropriate for beneficiaries to pay for special amenity or option services, this proposal allows providers to pass on to beneficiaries extra charges resulting from inefficient operations. The proposal seems shortsighted. It is designed to limit the financial liability of the government, but does not exert effective incentive for providers to operate efficiently.

LIMITS ON PREVAILING CHARGE LEVELS

On this provision, we must express reservations. Succinctly put, the effect of this proposal, while advertised as cost control, would result in a transfer of some portion of costs to the consumer. In candor, this seems to be an attempt, predicated upon a fundamental mistake of the past which assumed there actually was something now called a "prevailing charge" to standardize costs.

The formula which is proposed is theoretical and has not been subjected to trial. The APHA is of the opinion that this proposal is no less necessary of trial than the prospective reimbursement concept and therefore would recommend experimentation rather than across the board national action. The remedying attempt incorporated in this section is illustrative of the fallacy of a piecemeal approach to assuring a national health program. If basic costs are to be covered, total costs should be included, not an arrangement whereby partial costs in some indeterminate percentage is transferred to the consumer. The APHA must speak out against instigation of a system of cost controls predicted upon an imaginary premise as illusory as a "prevailing charge" or of "customary charge," which controls costs to the government but not the consumer.

EMPHASIS OF OUTPATIENT CARE UNDER MEDICAID PROGRAMS

The intent of Section 225 of H.R. 17550 is in complete concert with a basic tenet of the APHA—namely, provision of necessary care at a treatment "point of reference" most appropriate to need. Prior to the enactment of Titles 18 and 19, we have contended that these programs should not follow the myopic lead of most third party insurers, who place a premium upon primary insurance at the point of highest cost, namely, the hospital and next the extended care facility.

This is a fiduciary, *not* a health care approach. And it results in overuse of the expensive facilities. We support the validity of facilitating more ambulatory care. We are concerned that the method proposed will throw more of the cost of long-term care on to the States. Also, resources need to be supplied to increase the nation's capacity to provide more outpatient services.

In the change of emphasis, to which we wholly subscribe, we recommend (1) experimentation as suggested previously with respect to prospective reimbursement and with limits on prevailing charge levels, (2) identical provision for both Titles 18 and 19 and (3) a front end allocation from the funds used for benefits (for Title 18) and general revenue (for Title 19) funds to be made available for construction of needed facilities for outpatient care.

We must protest the arbitrary and discriminatory action proposed on Page 85 of H.R. 17550 relative to psychiatric patients. A choice of illness, mental or other, is not voluntary on the part of an individual and it is our view that such differences in benefits should not exist.

TERMINATION OF PAYMENTS TO SUPPLIERS OF SERVICES

The APHA subscribes totally to both the concept and procedure proposed to curtail abuses of this health services payment program.

ELIMINATION OF REQUIREMENT THAT STATES HAVE COMPREHENSIVE MEDICAID PROGRAMS BY 1977

The APHA opposes this action—not because we are persuaded as to the viability of the Title 19 program, but because of our conviction that a nationwide health care program is needed. Our Association is presently deeply involved in recommendations to this end. We are convinced that Medicaid is not the final answer, but until a preferable method is devised, the scope of services provided by the current plan should not be reduced. These services are needed by the people, who are beneficiaries.

REASONABLE COSTS OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MCH PROGRAMS

This proposal is another reminder of "sins past." Prior to the enactment of Medicaid and while numerous discrepancies were to exist between the provisions of Title 18 on one hand and of Title 19 and MCH programs on the other, parity was to obtain relative to inpatient hospital services charges. With no guaranteed improvement in the quality of services, up to one-third fewer funds were to be available for Crippled Children's services. And once again, we have that controversy, that discrepancy between two unrelated terms, charges and costs. Certainly this inequity should be eliminated and even more importantly, a relationship between charges and costs must be found.

INSTITUTIONAL PLANNING UNDER MEDICARE

The APHA supports totally the concept espoused in Section 231 of H.R. 17550. We would hope that this Committee would strengthen the provision which, as we understand it, calls only for a one-year budget and a three-year capital expenditure plan. We believe this inadequate to the need and recommend two additional requirements—the first, to require a relationship to the regional planning agency or the state planning agency, and the second, that consultation with state and regional planning authorities be made a requisite.

INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Federal supports (90 percent for installation and 75 percent for operation) for much-needed information on the Medicaid program is very worthwhile. We suggest, however, that much more than claims processing is needed, and in fact, may have been intended. If the latter is the case, specificity is needed to assure the evaluation of medical services is facilitated. Such information is essential to an intelligent Medicaid operation.

We must insert one word of caution. In accord with APHA's long-standing position vis-a-vis the confidentiality of vital statistics, we urgently request that strong safeguards against disclosure of information on individuals be included in this authority.

ADVANCE APPROVAL OF EFC'S AND HOME HEALTH COVERAGE UNDER MEDICARE

To this proposal we extend our unqualified support. We wonder why identical authority should not apply to Medicaid? Certainly this procedure will obviate the costly experience of disallowance of claims after-the-fact and it goes far to introduce to a greater degree than at present a medical judgement as to health need. We support the concept, but we believe the procedure would be improved if an appeal mechanism was included. And we would hope the Committee would insist upon simplified standards and procedures to implement this provision.

REASSIGNMENT OF CLAIMS

We support this provision without qualification. In brief, it will guard against unethical—even immoral—practices, and it is overdue.

UTILIZATION REVIEW—UNDER MEDICAID, MCH, AND CC PROGRAMS

This endeavor is one with which we are in complete accord, but our expectations are dampened by the rather spectacular lack of achievement under Title 18. May we suggest that the utilization review procedure needs strengthening overall. To this end, we recommend that the results of utilization reviews, in terms of patterns of care, on a non-individual basis, be made a matter of public record and that they be made available to community health planning agencies who are especially in need of such information. We should like to point out that utilization and quality control are closely related and the mechanisms used should be concerned with the quality of the services as well.

ELIMINATION OF REQUIREMENTS THAT COST SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOME

If we interpret correctly, the provisions of Section 236 of H.R. 17550, we are opposed to the proposal. Deductibles for the medically indigent create a financial hardship on the selfsame persons Title 19 was intended to assist. Deductibles are a barrier to care.

UNNECESSARY ADMISSIONS TO HOSPITALS AND ECF'S UNDER MEDICARE

We support this provision.

STATE HEALTH AGENCY RESPONSIBILITIES UNDER MEDICAID AND MCH PROGRAMS

The proposal contained in Section 238 of H.R. 17550 is a good beginning. The APHA believes the authority for the Title 19 program should be the responsibility of State Health Agencies. Medicaid is a health program for the poor and the

medically indigent. It is not a welfare program with health overtones. State health departments are far more competent than are its sister welfare agencies to evaluate the qualifications of health providers. Similar responsibility is in the main currently vested in State Health Departments for Medicare and MCH and CC programs. For the best and most consistent use of state government resources, similar responsibility for Medicaid programs should be assigned to State Health Departments.

HEALTH MAINTENANCE ORGANIZATIONS

The concept of a health maintenance organization is the single most refreshing amendment proposed by the Administration. Unfortunately, something seems to have been lost between what we understood was proposed and what is included in H.R. 17550, namely the element of prevention. It should be included. Admittedly, preventive health measures, in the classical sense, e.g., vaccinations are not so applicable to persons 65 years of age and older as they are to the young but within the broad spectrum of health care for older persons numerous preventive procedures would decrease suffering, reduce disability, and would be economical. Such provisions should be added.

Now to the proposal—we see a number of deficiencies.

Financially speaking, we see no stimulus to providers to originate HMO's and with no "front end" money, it would appear that even if properly motivated, the chances for success would be dim. Hence, we believe it imperative that sponsoring funds be provided. The use of a 5 percent tax for just this kind of purpose would be crucial.

Further, we are baffled by reference to an apparent penalty—95 percent of the total of A and B—to which HMO's could aspire. Certainly with such a limitation, there would appear to be little if any advantage for the individual to get his service from an HMO. Certainly, a clearer definition of what would constitute an HMO, safeguards against under-utilization under the contemplated prepayment program and responsibility for standards surveillance within a public agency are a requisite.

EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID PROGRAMS

We wish to express APHA's disapproval of an exception to recognized, accepted and approved requirements, be they for nursing homes, hospitals, or any other facility. There simply cannot be any divergence from minimum health standards irrespective of the sponsorship of facilities. It is the health of beneficiaries which is the sole measure.

CHIROPRACTORS' SERVICES

We do not believe that another study of the validity of chiropractors' services would provide information which is not already available. We believe strongly that the provision of chiropractic service is inappropriate and antithetical to high standards of quality care.

THE STUDY OF THE ESTABLISHMENT OF COVERAGE TO DISABLED BENEFICIARIES

The APHA has already taken the position that coverage should be extended to the disabled who are already receiving cash assistance from the Social Security Act. We should like to strengthen the recommendations that were made in the Committee report that special attention be given to the implementation of such a policy.

Senator ANDERSON. Thank you very much. It is a very fine presentation.

Dr. KIMMEY. Thank you, sir.

Senator ANDERSON. Miss Blanchard.

Reverend Eggers.

Mr. Tresnowski, senior vice president for government operations, Blue Cross Association.

Mr. Gottlieb.

STATEMENT OF SYMOND R. GOTTLIEB, PRESIDENT, ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES; ACCOMPANIED BY WILLIAM McC. HISCOCK, DIRECTOR, AND JOHN DONAHER, DIRECTOR

Mr. GOTTLIEB. Mr. Chairman, I am Symond Gottlieb, executive director of the comprehensive health planning agency of southeastern Wisconsin, and president of the Association of Areawide Health Planning Agencies.

With me to help answer questions, if needed, are Mr. William Hiscock, my counterpart from Baltimore, and Mr. John Donaher, my counterpart in Boston.

We are speaking today on behalf of the Association of Areawide Health Planning Agencies, representing most of the operational local health planning agencies in the Nation, including those that receive part of their funding under section 314(b) of Public Law 89-749 and those that, for a variety of reasons, do not now receive such direct Federal support.

The association has submitted for your consideration a full written statement which describes the purposes and functions of areawide health planning agencies and which makes detailed comments and suggestions on aspects of the legislation under discussion today.

Although our association's member agencies have a strong interest in all aspects of the proposed amendments to the Social Security Act, we have elected today to concentrate our discussion upon those sections of H.R. 17550 that can or should have the most direct relationship to areawide health planning. Our testimony today is based upon two major concepts that deserve emphasis and reinforcement:

First, areawide health planning agencies are unique and varied independent organizations developed by local communities, and should not be viewed as extensions of the State or Federal Government, even though they are cooperating closely with public agencies, may be partially financed by Federal funds, and are dedicated to local implementation of national policy as enunciated in the comprehensive health planning legislation.

Second, if the goals of areawide comprehensive health planning are to be achieved, Federal support must be provided for their efforts by maintaining a consistent approach to the planning process in all related legislation and by taking advantage of every opportunity to relate the operation of Federal health and financing programs directly to the activities of areawide health planning agencies.

These two concepts represent the essence of the "partnership" envisioned in Public Law 89-749 and supporting legislation and they reflect the approach to health planning in relation to the decision-making process that is most likely to obtain the results we are all seeking.

Today we shall concentrate our attention on those sections of H.R. 17550 that clearly affect the ability of the areawide health planning agency to carry out its functions or that are dependent upon a sound community planning process. We shall preface our specific comments only with the general observation that it is our hope that every pertinent section of H.R. 17550 should be scrutinized to determine whether

its administration can be aided by delineating a clear relationship to the community health planning process.

With respect to section 221, the Association of Areawide Health Planning Agencies endorses the purposes of section 221 of H.R. 17550, relating to medicare, medicaid, and title V, which would authorize the Secretary of HEW to refuse payment to institutional providers for the costs of unneeded capital expenditures. However, we strongly suggest modifications of section 221 to support the community planning process and more clearly to underline the Secretary's management responsibilities for the payment programs he administers.

As we read it, section 221 proposes that the Secretary would be compelled to cover the capital costs of any project which received the endorsement of both the areawide health planning agency and the State agencies involved. On the other hand, he would be permitted and under some obligation to disallow such costs if one or more of the planning agencies had recommended against the project. In effect, the bill would fully delegate positive approval powers to the planning agencies; and non quite delegate negative or disallowance power to the same agencies.

We submit that these provisions provide too great a handicap to the Secretary's management responsibility to provide effective administration of the billions of health care dollars represented by the three payment programs. We can see no good reason, in this instance, for the Secretary to delegate away his management responsibility to assure that Federal funds are appropriately used to meet health needs. Making decisions for the use of funds entrusted to him and planning for the use of those funds are a major part of the management responsibility of the Secretary.

Concurrently, areawide health planning agencies are primarily intended to develop more effective local health systems through strengthened planning processes and improved decisionmaking at institutional and community levels. We readily admit, by the way, that this is not the unanimous view of our member agencies; but it is the overwhelming position of our membership and is a firmly held belief of more experienced health planners. Section 221 would change a recommendation or advisory function to a virtual decisionmaking power over the placement of health facility capital development in the local community. In attempting to reach a commendable goal, section 221 inadvertently confuses the proper management function of payment programs with the planning process function of the areawide health planning organization, potentially destroying the planning function as a result.

Specifically, therefore, we believe that section 221 should be revised to spell out the intent that the Secretary or his designees, shall make all decisions with respect to reimbursement for capital expenses, taking into account the recommendations of the appropriate areawide health planning agency whether such recommendations are favorable or unfavorable, without being constrained to follow such recommendations. In making this recommendation, we emphasize the importance of the advisory role of the planning agency while confirming the decisionmaking role of the payment program, to make decisions about its own expenditures.

We suggest that it would be entirely feasible and much more practical to have the Secretary, in partnership with the delegate State

agencies under titles XIX and V and the fiscal intermediaries under title XVIII, determine whether a proposed health facility capital expenditure is consistent with the intent and capacity of the payment program in addition to its consideration of the advice of planning agencies concerning community needs for the proposed facility.

In carrying out this process, early submissio to the areawide health planning agency should be encouraged and the Secretary should operate according to clearly developed guidelines with the help of an advisory council that includes areawide planning agency representatives. Such guidelines should provide a positive stimulus to good institutional planning. The legislation should also maintain and expand the use of the language requiring that determinations be made according to "standards, criteria, or plans" and eliminate any implication that an unworkable master plan should be developed, a master plan that is artificial, inflexible, cast in concrete and unworkable.

The full text of the association's testimony goes on to make a number of specific recommendations about section 221. We commend those recommendations to your attention.

In redrafting section 221, the association also specifically recommends that it be required that any proposed project presented by the sponsor to the areawide health planning agency in the context of the sponsor's long-range plan relating to the health needs of the community and showing relationships with plans of other health facilities in the community. We also strongly recommend that this section should provide for a fair hearing and for appropriate administrative and judicial review of any determination by the Secretary. It would also be most suitable to provide for payment by the Secretary to areawide health planning agencies for their expenses in conducting the required reviews of capital proposals to carry out their part of this Federal program.

With respect to section 231, this section would add to the medicare program's definitions of providers a requirement that, in order to participate in medicare reimbursement, institutional providers must have "in effect an overall plan and budget" that meets certain standards.

At this time, the Association of Areawide Health Planning Agencies opposes enactment of this section.

The association opposes section 231 not because we downgrade the importance of sound institutional planning but because we value it too highly to wish it subverted by this section.

The emphasis of the modern institutional planning process, or should be, on services and programs for defined populations, not principally on facility development. We suggest that section 231, because it focuses on the end-result details of one component of a long-range plan, would be counterproductive to its goals.

If enacted, this section would provide a bonanza to hospital management consultants, as health facilities desperately seek their services, with the resulting substantial increase in the cost of care—part of which must be borne by Federal sources. The section would also give the Nation a vastly inflated summary of the capital demands of the providers, a necessary result of a required capital budgeting process. And, this section will give somebody a virtually unadministrable and largely pointless chore in reviewing the tons of submitted docu-

ments, most of which will have been manufactured specifically for this submission.

Most importantly, the demand for an annual 3-year "capital expenditures plan" from each facility will prompt the institution to focus on "approved" bricks and mortar plans ahead of service goals and thus work against the efforts of areawide health planning agencies to develop useful program alternatives aimed at improving health care and containing costs.

The Association of Areawide Health Planning Agencies strongly recommends that section 231 of H.R. 17550 be deleted and suggests that Federal standards, if any, relating to institutional capital planning be applied as part of section 221 by requiring that one criterion for the approval of a capital expenditure must be that any capital project must be presented in the context of the institution's long-range program related to the community's health needs.

If section 231 should not be deleted, then the association recommends that the inflexible language specifying the need for and composition of an institution's planning committee be deleted in recognition of the plurality of approaches that may be effective. Furthermore, the association suggests that a reasonable time period for implementation of section 231, if enacted, would be at least 2 and preferably 5 years rather than 6 months.

With respect to section 239, this section permits the Secretary to negotiate under medicare a combined part A and part B per capita reimbursement rate with "health maintenance organizations" that meet certain criteria and that are able to deliver comprehensive services.

The Association of Areawide Health Planning Agencies endorses the purposes and thrusts of this section.

It has long been an accepted principle of community health planning that all people should have full access to a broad range of health services and, properly administered, section 239 should help to achieve that goal.

To increase the likelihood that this section will achieve its purpose, the association recommends that because health maintenance organizations are part of the local community's health resources, the Secretary be required to work closely with areawide health planning agencies in the development of these programs. The association also recommends that the Secretary be given reasonable flexibility in recognizing HMO's so that identical tests are not applied in all locations. For example, small programs in rural areas might be approved without meeting the tests of "comprehensiveness" that should be applied to well-established organizations in metropolitan centers.

Further, the association suggests that in order to stimulate the growth of HMO's and their use by beneficiaries the 95 percent of average cost limitation be waived during the formative stages of an HMO, and the Secretary should be urged to be broadly permissive in approving HMO proposals. Use by beneficiaries will be stimulated if the HMO is able to provide broader services and/or eliminate coinsurance and deductible payments within the 95 percent limitation. Such provisions in the law would help to clarify the congressional intent to stimulate HMO development.

OTHER COMMENTS

The Association of Areawide Health Planning Agencies stresses its belief that the specific provisions of the Social Security Amendments of 1970 should take advantage of every opportunity to relate events to the local planning process. Such relationships improve the administration of the social security program and buttress the effectiveness of the areawide health planning agency. For example, section 222 should be revised to ensure that among the "specialists" consulted by the Secretary in prospective reimbursements experiments is the appropriate areawide health planning agency. And, section 223 should make it clear that the cost of planning by institutional providers is not a target for reimbursement-reducing measures. And, section 232, concerning payment to States to develop and operate "information retrieval systems" should clearly require that such systems should be developed in consultation with areawide health planning agencies, and that the health planning agencies should be guaranteed access to the data generated by such systems for planning purposes.

Thank you for your attention to our point of view, and if we can answer any questions we would be glad to be of assistance.

(The statement of Mr. Gottlieb follows. Hearing continues on page 726.)

TESTIMONY ON BEHALF OF THE ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES*

Appearing on Behalf of the Association:

Symond R. Gottlieb, President, 110 East Wisconsin Avenue, Milwaukee, Wisconsin.

Steven Sieverts, Vice-President, Chatham Center, Second Floor, Pittsburgh, Pennsylvania.

William McC. Hiscock, Director, 701 St. Paul Street, Baltimore, Maryland.

We are speaking today in behalf of the Association of Areawide Health Planning Agencies, representing most of the operational areawide health planning agencies in the nation, including both those that receive part of their funding under Section 314(b) of the comprehensive health planning legislation and those that, for a variety of reasons, do not now receive such direct federal support.

The proposed legislation under review today builds into certain federal financing mechanisms a new role for areawide health planning agencies. We can expect this to be only one of many measures to be proposed to build partnership into the relations between areawide health planning agencies and the federal government, and to strengthen health planning in local communities.

All of this public attention to and, indeed, faith in areawide health planning is gratifying, of course. It is with some trepidation, then, that we urge a degree of care and caution in assigning a variety of functions to the agencies that have have been formed in local communities to improve the effectiveness of their comprehensive health services through strengthened planning.

By way of introduction, one point should be made entirely clear: areawide health planning agencies differ widely, although they do generally share some basic characteristics, as shall be mentioned later in this statement.

Section 314(b) of P. L. 89–749 has resulted in organizational activities in literally hundreds of communities across the nation to respond to the mandate of areawide comprehensive health planning. In each of these communities, the approach and the dynamics of organizing the planning agency have been unique and different over a wide range. Particularly in the major metropolitan regions, there was frequently already a history of areawide health planning, usually with partial funding from the federal government under Section 318 of the Public Health Service Act, although in about a dozen instances the planning agency's existence preceded even that federal interest and support. In most of

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the communities which are currently involved in areawide health planning, however, the enactment of Section 314(b) provided the principal initial stimulus for action—and in all cases, Section 314(b) prompted local ferment regarding health planning.

In any event, the fact is that the field of areawide health planning is going through a period of extraordinarily rapid growth and change both nationally and, more significantly, in hundreds of local areas. It should be understood that Section 314(b) did not create a set of relatively uniform agencies as did, for example, the legislation creating the Regional Medical Programs or O.E.O. Neighborhood Health Centers. Partly because of regrettably inadequate staff guidance from the Department of Health, Education, and Welfare, but more importantly because the challenge was inevitably understood and interpreted differently by the various forces and interests in each locale, each agency has developed in its own way, and most of them are still in their infancy.

In some areas, enlightened consumer and professional interests have combined to create viable and competent areawide health planning agencies. In other areas, however, the process has been slow and uneven—and in a few instances even divisive and demoralizing rather than unifying and stimulating.

The federal leadership, in guiding communities in developing areawide comprehensive health planning, has tended to place its major emphasis on the *structure* and *composition* of the areawide comprehensive agencies and relatively little on the agencies' *programs*, on what they are expected to do. Partly as a consequence, the agencies already in operation and the larger number in the organizational phase have come up with a variety of definitions of their own functions. While these definitions reflect the diversity of the approaches taken around the country, they do tend to include some common threads.

The Association of Areawide Health Planning Agencies, drawing upon many years of experience in areawide comprehensive health planning, feels competent to suggest that the agencies have the following basic functions and characteristics:

(1) *The areawide agency should be a creature of the local community*, not to be viewed as an instrument of the State or federal government. Of course at least half of its budget must be raised locally (usually from private sources), but money aside, it should in all ways act as a consumer-dominated agency with broad provider participation, concerned primarily with affecting the community's decision-making processes relating to all aspects of the health of the people living in the area.

(2) The principal function of the areawide comprehensive health planning agency must be the *development and strengthening of the processes of planning* in the community that result in decisions which bear on the health of people. This function includes:

(*a*) Fact-finding concerning needs, resources, and the characteristics of the community and its people;

(*b*) The establishment of guidelines for the orderly planning and development of needed services, facilities, and manpower;

(*c*) The identification and evaluation of alternative courses of action;

(*d*) Building into institutional planning activities both a sensitivity to consumer interests and a participatory role for community representatives; and

(*e*) The evolution of community goals and priorities related to the health of the people.

(3) Another principal function of the areawide comprehensive health planning agencies is *community dynamics*, bringing together and enhancing practical dialogue among and within provider groups, professional groups, community groups, unorganized consumers, local government, educational agencies, and so on. This function is aimed at increasing the relevance and practicality of health planning at all levels, achieving acceptance and use of the tools of effective planning, and helping to assure sound program development.

(4) Finally, the areawide comprehensive health planning agencies must be concerned with *implementation*, which includes the following elements:

(*a*) Assistance to individual institutions, agencies, and community groups to improve their planning capabilities, to help them to make use of planning tools, and to encourage them to explore alternative courses of action;

(*b*) Providing the setting, the framework, and the stimulation for coordination of the planning and programming of institutions and agencies of the same or different types, including community groups that intend to initiate health programs;

(c) Review of proposed program developments or construction projects to advise the institution or agency, all financing agencies (capital and operations financing), and the general public as to whether the proposals meet a demonstrated community need, are financially feasible, fit in with community priorities, and have been developed in accordance with sound planning principles in the opinion of the planning agency;

(d) Advice to decision-makers, especially fiscal authorities, concerning the most appropriate use of resources within the community generally; and

(e) Assistance to providers of care, individually and in groups, in their search for resources for programs that are in the community's best interests.

In summary, then, we are making the points that the areawide health planning agencies are local institutions in various stages of development, have heterogeneous structures and approaches, and most importantly, have built up a body of experience which should serve to provide guidelines both for the agencies themselves and for the public sector in its dealings with them.

SPECIFIC COMMENTS CONCERNING H.R. 17550

H.R. 17550 has thirty-two sections which relate to the medicare, medicaid and Title V programs to purchase health services for people. The Association of Areawide Health Planning Agencies, because of its mandate to be concerned with all aspects of comprehensive health services, is interested not only in these sections but also in many of those which relate to income maintenance, disability protection, and other measures which affect the general health of the people. The Association, however, will limit its observations today to Sections 221, 222, 223, 231, 232, and 239, with the major emphasis on Sections 221 and 231, the first relating to limitations on reimbursement for capital expenditures of health providers under federal payment programs, and the second adding a requirement for "institutional planning" under the definitions of such providers. These six Sections, and particularly Sections 221 and 231, have direct and obvious relationships to area wide health planning, and it is on these matters that we presume that our specific comments will be most useful to this Committee and to the Senate.

SECTION 221.—LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

The Association of Areawide Health Planning Agencies strongly endorses the purposes and the bulk of the details of this Section of the proposed legislation, which would authorize the Secretary of H.E.W. to refuse payment for the costs associated with un-needed capital expenditures. Leaders in the areawide health planning field, along with such provider organizations as the American Hospital Association and the Blue Cross Association, have long been insisting that the third-party payment agencies should develop management and control tools so that their reimbursements will create incentives favoring the effective delivery of needed health services. The Social Security Administration has become America's largest third-party purchaser of health care and should be given such tools. This Section would help to accomplish this aim.

Section 221's purpose is "to assure that Federal funds . . . are not used to support unnecessary capital expenditures made by . . . health care facilities . . . and that, to the extent possible, reimbursement . . . shall support planning activities with respect to health services and facilities . . ."

Each State would designate an agency to review all proposed capital expenditures of $100,000 or more by any health care provider participating in the medicare, medicaid, or Title V (Children's) programs. The State agency would report to the Secretary of H.E.W. its findings and recommendations, along with the findings and recommendations of the areawide health planning agencies plus certain other State-level planning agencies.

The Secretary would receive these various recommendations and, if any of them are negative regarding the specific capital project in question, would disallow Federal payments to that provider under the medicare, medicaid and Title V programs with respect to "any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital . . . or other expenses related to such capital expenditure". The Secretary is empowered to over-rule any negative recommendations and approve capital cost payments if he decides that the exclusion of these expenses would go against either effective organization and delivery of health services or effective management of one or more of the three Federal payment programs.

Let us put this into simpler language. If a hospital (or other health provider) proposes a capital development project of $100,000 or more which fails to get the endorsement of various selected State planning agencies or the areawide health planning agency, that hospital would not receive federal reimbursement for the capital expenses it incurred unless it (or somebody else) were able to convince the Federal authorities that they should, in effect, over-rule the local or State recommendation.

The Association of Areawide Health Planning Agencies favors the goal of this Section but has serious questions about several of its approaches.

The Section spells out many details about procedures, timing, funding, and so on, several of which we will touch on later. We would like to focus principally, however, on two basic and closely-related issues: the limited discretionary powers granted to the Secretary in this vital phase of his management responsibility, and the appropriate function of the areawide health planning agencies in achieving more effective health delivery in local communities.

As proposed in H.R. 17550, as we read it, the Secretary would be *compelled* to *cover* the capital costs of any project which received the endorsement of both the areawide health planning agency and the State agencies involved. On the other hand, he would be *permitted* and under some obligation to *disallow* such costs if one or more of the agencies had recommended against the project. In effect, the bill would fully delegate *positive* approval power to the State and areawide agencies; and not-quite-delegate *negative* or disallowance power to the same bodies.

We suggest that these provisions provide too great a handicap to the Secretary's management responsibility to provide effective administration of the billions of health care dollars represented by the three payment programs.

At the same time, these restraints on the Secretary, by delegating too much management authority to the areawide health planning agencies, would give those agencies an assignment which most of them are not constituted to undertake and which would be, to some extent at least, counterproductive to their principal aims and activities.

Both in the experience of the areawide health planning agencies and in the draft Federal guidelines and policies regarding areawide comprehensive health planning programs, the main thrust has been to develop more effective local delivery of health services by developing strengthened planning processes and improved decision-making at institutional and community levels. The areawide health planning agencies, most of them formed in the past decade, are developing a variety of approaches to accomplish this goal of strengthened planning, as discussed earlier. One of their tools, but by no means the most important, is the establishment of a community review process which produced advice about proposed health facility projects. This advice gathers its authority from the prestige of the planning agency, the atmosphere of cooperation among the health providers in the community, the validity of the facts and judgments which led to the agency's position, and the support for better planning among paying, licensing, and endorsing bodies.

The details vary somewhat from region to region, but in general the areawide health planning agencies' advice about facility projects is or could be directed, to the following: (1) the sponsor of the proposed project, (2) the contributors, if any, of privately donated capital, (3) governmental funding agencies if governmental grants or loans are involved, (4) public and private third-party purchasers of health services, (5) local and State regulatory and planning agencies, and (6) lending agencies if debt financing is to be incurred.

In addition, the recommendations of the areawide health planing agency, because of its representative governing structure, because of the credibility of its review procedures, and through the use of communications tools, have persuasive impact through the force of public opinion and consumer action.

The enactment of Section 221 would greatly increase the legal or quasi-legal power, as distinct from the influential persuasiveness of the planning agencies' recommendations about facility development and would therefore very likely make this aspect of the planning agencies' work much more visible and predominant. In so doing, Section 221 would change the planning agencies' role markedly, both by putting disproportionate emphasis on the control of capital placement, and by giving them a regulatory role rather than a planning role.

H.R. 17550 would change a recommendation function to a virtual decision-making power over the placement of health facility capital development in the local community, as almost no health facility will try to function without income from one or more of the three federal payment programs.

We suggest strongly that in attempting to reach a commendable goal, the drafters of Section 221 have inadvertently confused the proper *management* function of payment programs with the *planning process* function of the areawide health planning organization.

We can see no good reason for the Secretary to delegate away his management responsibility to assure that medicare, medicaid, and Title V capital dollars go only to facilities which serve community needs. Through the Social Security Administration, the State medicaid agencies, State health departments and the fiscal intermediaries, for example, the Secretary is able to develop quite subtle and sophisticated control techniques over what to pay providers. (Several other Sections of this bill are examples of this.)

Specifically, we believe that Section 221 should be revised to spell out the intent that the Secretary, or his designees, shall make all decisions with respect to reimbursement for capital expenses, taking into account the recommendations of the appropriate areawide health planning agency whether such recommendations are favorable or unfavorable, without being constrained to follow such recommendations.

We suggest that it would be entirely feasible and much more practical to have the Secretary in partnership with the delegate State agencies under Titles XIX and V and the fiscal intermediaries under Title XVIII (and seeking advice from planning agencies), determine whether a proposed health facility capital expenditure is consistent with community needs.

This process would require machinery, we suggest, which should encompass the following principles:

(1) The project should have been submitted to the areawide health planning agency well in advance of any State or federal reviews;

(2) The areawide health planning agency should be requested for recommendations in advance of any State or federal review;

(3) The project should be presented by the sponsor in the context of his long-range plan relating to the health needs of the community and showing relationships with the plans of other health facilities in the community;*

(4) The Secretary, in making determinations, should follow criteria and procedures laid down in guidelines drawn with the aid of the advisory council mentioned in subsection (i) of the legislation, drawing on the experience of existing areawide health planning agencies;

(5) Any party which expresses concern over any impending or accomplished determination by the Secretary should have the right to a fair hearing, and similar rights should be guaranteed by any State or fiscal intermediary which plays a part in making the decision;

(6) The determinations of the Secretary should be subject to proper administrative and judicial review; and

(7) To the extent possible, the implementation of this Section should be seen as a force to achieve sounder planning by the health care providers, not merely as a tool to penalize the unworthy. The Secretary should be encouraged to view capital expense reimbursement as an incentive tool to help achieve a more effective health system, not as a plum to be withheld from the greedy, and more importantly, not as the be-all and end-all of the health planning process.

Some additional comments on this Section are in order, mostly relating to important details or a need for clarification.

First, Section 221 appears to have the Secretary paying out of medicare funds for review activities as specified in individually negotiated agreements with the States. A major part of the review effort is to be conducted by areawide health planning agencies. We suggest that provision be made for negotiated reimbursement of any extraordinary costs incurred by those agencies in conducting such reviews.

Second, we applaud the language in subsection (6) which refers to "standards, criteria, or plans", thus apparently foregoing the temptation to tie capital reimbursement to comprehensive or areawide master plans which are probably unworkable in the personal health services field. The remainder of the sentence, however, refers to development "pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Construction

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*This principle is the recommendation of the Association of Areawide Health Planning Agencies as a partial substitute for Section 231, which is discussed in greater detail below.

Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed".*

In this context we would like to direct the Committee's attention to Sections (3) and (4) of Section 221, in which the conforming changes refer several times to "comprehensive plans" of areawide health planning agencies rather than to "standards, criteria, or plans" as used earlier. We urge clarification and consistency on the point that the areawide health planning agencies are not expected to draw up monster "comprehensive plans" to serve as the guide for payment agencies, but rather should be requested for locally sensitive advice based on their own standards, criteria, or plans.

Finally we suggest that due notice be paid to the fact that many "natural" health planning regions are inter-State in nature, so that it frequently happens and will happen that an areawide health planning agency headquartered in one State is working with health facilities in another State (and even in another HEW Region). In drawing up the procedures to implement Section 221, the Secretary should be encouraged to permit inter-State agreements to be negotiated.

SECTION 231.—INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

Briefly, this section would add to the medicare program's "definitions of providers" a requirement that, in order to participate in medicare reimbursement, institutional providers (hospitals, ECF's and home health agencies) must have "in effect an overall plan and budget" that meets certain standards. At this time, the Association of Areawide Health Planning Agencies opposes enactment of this Section.

The Association of Areawide Health Planning Agencies opposes Section 231 not because we downgrade the importance of sound institutional planning but because we value it too highly to wish it subverted by this Section.

Most operational areawide health planning agencies have stressed the responsibility of provider institutions to have active long range planning and operational budgeting processes. The purpose of this Section of the proposed amendments is, presumably, to add legislative "teeth" to this fundamental principle of health planning.

The crucial question, however, is whether legal sanctions are the best way to achieve long range planning or budgeting by providers, or even whether this approach can work at all.

The bill is silent about whom receives copies of the newly required documents (a capital plan and a budget), but if a test of "insufficiency" is to be applied in deciding whether a provider qualifies for medicare participation, then presumably the State and federal agencies which certify providers would review and approve these documents.

Development of a modern health institution's long range planning process requires, in most instances, profound changes in how the institution goes about making corporate decisions. The role of the governing board changes from a simple fiduciary one to a policy one. The medical and professional staff is brought into the action in broader and more powerful ways. The function of the executive is strengthened and deepened. Subtle and difficult changes are required in how various people view the institution, its environment, and its social purposes.

Out of a vitalized and modern institutional planning process can come a functional long range plan focussed on community goals and on the role of the institution in service to the community. The emphasis of such planning is on services and programs for defined populations, not principally on facility development.

The long range plan usually contains a capital development component. This component, as it becomes refined in the institution's ongoing planning, has the

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*The Report of the Committee on Ways and Means doesn't elaborate on the precise meaning of this phrase, but does imply that "plans" drawn by areawide health planning agencies are to be the guide. We point out that most areawide health planning agencies do not draw up areawide "plans" as such—and none do at the level of most $100,000 capital projects. All operational areawide health planning agencies, however, have standards, principles, or criteria which can be and are applied to proposals, large or small. The Committee Report also implies that all areawide health planning agencies and, for that matter, relevant State agencies are established pursuant to federal health legislation. This is not invariably the case and it is difficult to imagine that the Committee meant to limit this bill's impact to only the areas whose planning agencies are funded by Public Health Act funds, especially when those federal appropriations have been exhausted.

potential for creating positive change in the effectiveness of the health system. The planning of buildings and equipment, however, is a process secondary to the planning of services and relationships.

We suggest that Section 231, because it focuses on the end-result details of one component of a long range plan, would be counterproductive to its goals. Institutions would not only be given a powerful incentive to focus on over-stated capital development instead of sound long range planning, but they would also be given implied justification for skipping the onerous long range planning process altogether if their capital development planning documents appear to meet federal standards.

Three outcomes of this Section, if enacted, are clear. First, the hospital management consultants would have a bonanza with thousands upon thousands of hospitals, nursing homes, and home health agencies having to buy expensive help to produce the documents required by the law, especially within the stated timetable. This bonanza would, of course, add greatly to the cost of care. Most of the specified providers do not have the competence now to produce the required reports, and would perforce have to engage in a sellers' market to purchase skilled help in fulfilling the law's literal requirements.

Second, the nation would be given a vastly inflated summary of the capital demands of the providers, because common sense tells each provider to think big when filing his future with the government.*

And third, somebody will be given a virtually unadministrable and largely pointless chore in reviewing the tons of submitted documents, most of which would be manufactured specifically for this submission.

Obviously the federal government should encourage each health facility to develop an effective planning process. The areawide health planning agencies would welcome such support. We suggest, however, that demanding an annual three year "capital expenditures plan" from each facility (mis-labeled an "overall plan" elsewhere) will prompt the institution to focus on "approved" bricks and mortar plans ahead of service goals, and thus will foul up the efforts of areawide health planning agencies to develop meaningful planning processes in the community.

This Section is also unsatisfactory in several of its details. For example, the bill has other portions calling for reimbursement experiments with prospective rates. We suggest that any requirements related to "an annual operating budget which includes all anticipated income and expenses" belong in the guidelines for reimbursement. Indeed, if experimentation with prospective rate-setting is to go forward, this would dictate the submission of competent budgets.

Further, while the areawide health planning agencies perhaps invented the device of a health institutional governing board planning committee including administrative and medical staff, we have learned that there are valid variations on that theme. Some institutions do better with advisory committees and/or with professionally staffed planning departments, for example. It seems unnecessarily and unwisely rigid to require a specified planning structure at each facility.

Next, if such a Section is enacted, a reasonable time period for implementation would be two, three, or five years, not five or six months. Even overtime bonuses by the consulting firms couldn't produce such documentation so quickly.

The Association of Areawide Health Planning Agencies suggests that federal standards, if any, relating to institutional capital planning be applied at the time capital projects are being reviewed under the provisions of Section 221 and futher, that the Secretary, in implementing that Section, use as one criterion for his approval of a capital expenditure a requirement that any capital project must be presented in the context of the institution's long range program plans related to the community's health needs. In other words, we urge the deletion of Section 231 and an amendment to Section 221 as noted.

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*Why would this Section lead to overstated estimates of capital needs? For several reasons. First, the provider doesn't know whether his failure to announce a possible capital project mightn't result in some kind of future ineligibility for funding. (This is already a reality in the annual Hill-Burton sweepstakes.) Second, the provider makes no commitments by filing a plan. Third, individual institutional plans are unlikely to be tempered by the limits of community capital resources. And finally, it is inherent in the governance of any institution to aspire to become in all ways bigger and better. On balance, areawide health planning agencies have learned that a larger proportion of announced plans never materialize—and when development does occur, it frequently is substantially different (and usually on a smaller scale) than the original press releases predicted.

SECTION 222.—REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT, AND SO FORTH

This Section authorizes demonstration projects or experiments to test the usefulness of prospectively determined institutional reimbursement rates as a technique to hold down health care costs. The Association of Areawide Health Planning Agencies endorses this Section.

We would, however, like to make some comments about Section 222. First, there continues to be a need for experimentation with reimbursement as an "effectiveness tool" in forms other than prospective payment schemes. (Indeed, the new enthusiasm for prospective rates may be based on not entirely valid assumptions about how health facilities behave.) We suggest that clear room be left for small-scale experiments as well as large, and for experiments in techniques other than prospective rates, such as development of new controls in cost-based reimbursement, and so on. (On the matter of prospective rate reimbursement, this, we suggest, is where any references to institutional budgets belongs, if anywhere.)

Second, the Secretary would be required to consult "specialists" before authorizing any projects. We suggest that he should be encouraged to work specifically with such vitally concerned groups as the areawide health planning agencies, the fiscal intermediaries (many of whom have broad practical experience in the matter), and the associations of providers (some of whom are also well-versed).

Third, we suggest that July 1, 1972 is much too soon to expect a comprehensive report to the Congress on the implementation of this Section. Allowing for time to staff the activity and develop the technical details and institutional agreements, how much operational experience would there be to report? And how valid would observations be of demonstration projects whose participants know that the thing might end in a few months?

SECTION 223.—LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

This Section spells out the Secretary's responsibility to cover only those costs attributable to cover "necessary" and "efficient" care.

The Association of Areawide Health Planning Agencies will not take a position on this Section as such, except to express the hope that if such a provision is enacted, it will be interpreted as discouraging the nation's health facilities from undertaking sound long range planning activities. Such activities do cost money and there have already been some hints that they might be a target for reimbursement-reducing measures. We urge the Congress to encourage the institutions providing health services to invest in strengthened planning.

We suggest that while a "reasonableness" test should be applied to an institution's planning expenses, this legislation spell out clearly that planning is an indispensable and, indeed, necessary part of the institution's management.

SECTION 232.—PAYMENT TO STATES . . . FOR THE IMPLEMENTATION OF . . . INFORMATION RETRIEVAL SYSTEMS

This Section would amend the Social Security Act by permitting federal funds to be paid to the states for 90% of the developmental costs plus 75% of the operating costs of "mechanized claims processing and information retrieval systems" as they relate to medicaid programs.

There is considerable effort around the country to develop Statewide or regional health data systems. Some ventures are funded or are up for funding under Sections 314(a) and/or 314(b); others from the National Center for Health Services Research and Development, the National Center for Health Statistics, or elsewhere in the federal establishment. Some involve Blue Cross and hospital associations. This Section doesn't refer to other health information and data programs in existence or in planning.

The Association of Areawide Health Planning Agencies would like to suggest strongly that any Statewide or regional data programs funded under this Section or otherwise by the federal government be linked to related Statewide or regional projects, both for possible savings in dollars and for maximum effectiveness in developing health care data. As a general principle, we urge that all of these data programs be urged to share appropriate information with the community and to work for broad and practical utilization of all relevant health data.

We believe that Section 232 of this legislation should clearly require that such "informational retrieval systems" should be developed in consultation with areawide health planning agencies, and that the health planning agencies should be guaranteed access to the data generated by such systems for planning purposes.

SECTION 239.—PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

This Section permits the Secretary to negotiate under medicare a combined Part A and Part B per capita reimbursement rate with so-called "health maintenance organizations" that are abue to guarantee comprehensive services.

The Association of Areawide Health Planning Agencies endorses the purposes and thrusts of this Section.

It has long been an accepted principle of community health planning that all people should have full access to a broad range of health services. Section 239 would make it possible for medicare recipients to choose to participate in comprehensive group medical care plans, as federal employees and many other Americans now can do under their governmental group prepayment programs. More important, by adding considerably to their potential membership base, this Section could give a considerable boost to the development of comprehensive group medica lcare plans in communities where they do not now flourish.

We would like to make three suggestions regarding the implementation of this Section. First, because "health maintenance organizations" are part of the local community's health resources, we urge that the Secretary be encouraged to work closely with the areawide health planning agencies in the development of these programs. This is particularly important in regions where previous efforts to establish group programs have been beset with controversy. The areawide health planning agencies can play a most helpful role as the unique local forum for provider-consumer dialogue and for joint approaches to solving health care delivery problems. Even more important, development of the HMO's will require sound institutional and community planning by the people trying to establish them. The areawide health planning agencies are prepared to offer substantial and practical assistance.

Second, we urge that the Secretary be given reasonable flexibility in developing HMO's so that, for example, small programs in rural communities or elsewhere can be approved without meeting the tests of "comprehensiveness" that would be applied to well-established organizations in metropolitan areas. The Secretary should be able to exercise options in establishing rates, in reviewing membership requirements, and physician reimbursement patterns, and in allowing innovative approaches to providing both prepayment coverage and actual health service delivery

Third, we urge that the Congress clarify its intent to have Section 239 stimulate the organization of new programs in local communities, to be implemented in ways to encourage beneficiaries to choose this option. We suggest that the 95% cost limitation be waived during the formative stage of an HMO, and that the Secretary be urged to be broadly permissive in approving HMO proposals. Some should experiment with a greater range of services than is covered by medicare. Some should try variations on the co-insurance payments, and so on. Further, specific consideration should be given to the capital needs of HMO's, and to developing sound procedures to evaluate short- and long-range performance.

CONCLUSION

Thank you for your attention to the point of view of the Association of Areawide Health Planning Agencies. If we can answer any further questions or be of assistance to the Committee in any way, please feel free to call on us. Thank you.

Senator ANDERSON. Any questions? Thank you very much.

Mr. GOTTLIEB. Thank you.

Senator ANDERSON. Mr. Miller—Clinton R. Miller.

STATEMENT OF CHARLES ORLANDO PRATT, WASHINGTON GENERAL COUNSEL, NATIONAL ASSOCIATION OF NATUROPATHIC PHYSICIANS, ON BEHALF OF THE NATIONAL HEALTH FEDERATION

Mr. PRATT. Mr. Chairman, I am Charles Orlando Pratt, Washington general counsel for the National Health Federation, speaking for and in place of Mr. Miller, listed as vice president of the National Health Federation.

I shall speak here for a few minutes on behalf of another association, the National Association of Naturopathic Physicians, with headquarters at Portland, Ore.

At first, if I might, I would like to read a statement on behalf of the National Health Federation, and it reads as follows:

Statement on behalf of the National Health Federation in support of an amendment to the Social Security-Medicare Act of 1970 (H.R. 17550) to provide benefits to citizens for services of doctors of chiropractic under the program of supplementary medical insurance benefits for the aged:

Your witness, Charles Orlando Pratt, respectfully presents this statement on behalf of the National Health Federation, 211 West Colorado Boulevard, Monrovia, Calif., a nonstock, nonprofit, California corporation, which is devoted to health matters and the cause of freedom of choice in health care, provided such choice does not interfere with the health and welfare of others.

Throughout America it is apparent that the limited number of medical doctors cannot adequately care for all the citizens who need health care.

Medical doctors, because of the patient demand, are developing so-called physician multipliers or physician assistants. In general, these are persons trained as nurses—not necessarily even registered or graduate nurses. For example, such persons with limited training function by counseling, diagnosing and prescribing for patients in both health and disease. Some of these trainees or nurse-trained persons are involved in the role of being a physician multiplier. They are sometimes called health professionals. They are used because there are not enough medical doctors to care for the aged or other patients.

Licensed doctors of chiropractic are professionally trained in the basic sciences as are doctors of medicine. The extent and scope of the educational requirements of one qualified to practice chiropractic are well known to this committee. It is the second largest healing arts profession in America today.

The professional services of doctors of chiropractic are needed now, not to supplant doctors of medicine but to supplement them because doctors of medicine are too few and too over-burdened.

The National Health Federation urges Congress to amend the Social Security Act so that the citizens of the United States, who use the care of doctors of chiropractic licensed in their states, shall be entitled to all the benefits of the program of supplementary medical insurance for the aged.

The Federation believes that Congress should not make any law which will abridge the privileges or immunities of citizens of the United States in health care.

The Federation believes that Congress should not deprive any person of the liberty to choose his or her own kind of health care from, and by a duly licensed doctor of chiropractic.

The Federation believes that the citizens of the United States and the doctors of chiropractic, duly licensed by the state in which they practice, should not be denied by Congress the equal protection of the laws of the United States by denying them the benefits of the Social Security Act.

The Federation believes that the absence of a provision in the Social Security Act providing for payments for chiropractic services, under the program of supplementary medical insurance benefits for the aged, may, in truth, and in

fact, constitute an unconstitutional, and an unlawful abridgement of the privileges and immunities of citizens of the United States. Such denial does deprive the citizen of his property right and liberty to choose and use the healing arts care, which he believes is, or will be, most beneficial to him. Such denial does, indeed, deny the United States citizen the equal protection of the federal health laws.

The Federation believes that the freedom of choice in health care is an inalienable right, which is necessary to secure the blessings of liberty and to promote the general welfare in health matters.

The citizens who are patients of doctors of chiropractic, and the said doctors, are taxpaying citizens. Their taxes are used to pay for health and medical care and facilities under the Social Security Act. The use of this health care and of these facilities is denied the patients of the doctors of chiropractic; and thereby, their rights and privileges are denied.

The medical and allied professions, for whose services Congress has provided payment under the program of supplementary medical insurance benefits for the aged, may not be able to do the whole job of protecting the health and welfare of the United States citizens, because millions of Americans do not use or want drugs unless required by law, like the special innoculation, and so forth.

Millions of Americans are justifiably afraid to use the powerful drugs, antibiotics and medicines on the market today, because of the repeated public revelation by the government, the press, radio and television, that such products have dangerous, serious and sometimes deadly side effects. These citizens, therefore, want to have available to them the professional advice and care of licensed doctors engaged in the healing arts professions, who do not recommend or use in their practice such products.

Congress should do justice to all United States citizens by providing for the use of federal tax revenues, under the provisions of the Social Security Act, to pay for the health services of patients of doctors of chiropractic duly licensed under state law. One state does not provide for such a license; that is Louisiana. Mississippi allows it by way of a Court decision.

Patients of doctors of chiropractic should have the same and equal right to have federal assistance in paying their health bills as do the patients of the other healing arts professions. These citizens should not be deprived of federal assistance. American citizens should not be compelled, directly or indirectly, to be cared for, or treated, according to a majority opinion on health care.

America has grown strong by protecting minority rights against the overwhelming power and influence of the majority. This principle applies as much today in the need to protect the minority rights of the patients of the chiropractic doctors as it applies to protect the minority rights in religious or civil rights fields.

Congress should do no less than to protect the minority privileges and immunities of all Americans who need and want health care from the chiropractic profession.

Congress should do no less than to guarantee to all patients of doctors of chiropractic the equal protection of the Social Security Act. The best interests of the government and of the people will be served thereby.

Respectfully submitted, The National Health Federation, by Charles Orlando Pratt, Washington General Counsel.

In order not to repeat the principles set forth there on behalf of the National Association of Naturopathic Physicians, of which I am general counsel, I will make two or three sentences.

It is apparent before the hearings of the House Ways and Means Committee, and also before the hearings of this committee this morning, that these people are going to have to use much more care in medical health matters by people not necessarily trained as doctors of medicine or registered nurses. So, why not use all the professions which have been tried over the period of years that have been recognized by State legislatures and have been enacted into law and approved by the governments of the respective States?

As a matter of fact, I came across a statement in the Sunday Star, dated December 21, 1969. It was an article written by Carl T. Rowan,

which says: "AMA to push radical plan for public health care." It says here—let me read one sentence:

> But more critical to the high cost to millions of Americans is the fact that they cannot get adequate medical care at any price, and that is no shocking revelation to the residents of Small Town, U.S.A., who can't get a doctor to live there or to the residents of urban ghettos who are "off limits" to most doctors after sundown and, in some instances, in the daylight hours, too. Even prosperous Americans consider themselves lucky if they can simply get a telephone diagnosis and a few capsules prescribed by a competent doctor on a weekend or a Wednesday afternoon.

In view of this fact, Mr. Chairman, I express the same thought and ask you to read in the same legal and constitutional arguments on behalf of the patients of the doctors of naturopathic medicine who are licensed in the various States, some of them. I think, I do not know exactly how many States, but this organization maintains headquarters in Portland, Ore. There are a number of them, especially in New England and the South.

The fact that some of them have gone too far in their practice is also beside the point. As a matter of fact, sometimes lawyers have gone too far, and doctors of medicine have gone too far; sometimes legislators have gone too far, but let us not deprive the U.S. citizen of the right to have this kind of care.

For example, doctors of naturopathy believe pretty much in the natural approach to health; that is where it gets its name: Nature, in the natural fruits and vegetables; in fresh air and sunshine and natural vitamins and minerals and things like that.

Now, in some States they are allowed to use drugs and medicines, and they are under the control of the States and they are licensed by the State, and I believe it is not appropriate for Congress to distinguish which laws and which States it will recognize and which patients and which doctors it will recognize.

Therefore, Mr. Chairman and members of the committee, thanking you for your patience, I urge the Social Security—the Medicare Act of 1970, to include the right of all the millions of patients of doctors of chiropractic and doctors of naturopathy or any other licensed doctors or nurses, registered by the States and approved by their State medical boards, to carry on their profession.

With this, I believe we will improve the health conditions of the people in America. I want to assure you that I recognize the need for medical profession, and thank God for their profession and their hospitals and their care.

We just want to take care of all, whether we agree with those professions or not.

Thank you, sir.

Senator ANDERSON. Any questions?

Senator BENNETT. No questions.

Mr. PRATT. Mr. Chairman, in my hurry I neglected to ask that the committee insert into the record the statement I had here on behalf of the two national associations. One is a statement on behalf of the National Association of Naturopathic Physicians, presented to this committee, and the other is a statement on behalf of the National Health Federation, presented to the committee; and the other is a

statement by the president of the National Association of Naturopathic Physicians addressed to the Honorable Tom Vail, chief counsel.

I would ask that these be inserted in the record.

Senator ANDERSON. Without objection that will be done.

Thank you very much.

(The documents referred to follow. Hearing continues on page 757.)

[From the National Health Federation Bulletin]

WASHINGTON REPORT

(Clinton R. Miller, NHF Legislative Advocate)

HOW TO MEDICALLY STACK AN AD HOC STUDY COMMITTEE AND THWART THE INTENT OF CONGRESS

Early last year, Congress instructed the Department of Health, Education, and Welfare to make a study of the advisability of including other healing arts in Medicare. The report was to be ready for Congress when it started its present session. Congress intended, and took every reasonable precaution to insure that the committee which would make this study would be fairly representative of many points of view and would return to them an unbiased report to help them in drafting new legislation.

Congress wanted the report completed by January 1, 1969, and specifically instructed HEW to meet this deadline. Characteristically showing contempt for the Congressional target date, HEW didn't even appoint the committee until September, 1968, four months before the report was due. But the extent of HEW's arrogant disrespect of Congressional intent was not fully realized until we received a list of the "Ad Hoc Consultant Group Members."

"YOU'VE GOTTA BE KIDDING"

When I first looked over the list of the 22 members, I felt someone was "putting me on," as they say nowadays. I still find it hard to believe that anyone was serious in believing Congress would stand still for HEW's open insult to their intent that a FAIR committee be picked to study and report on the sensitive subject of fair representation of all licensed healing arts in Medicare.

Five medical doctors dominate the committee. There isn't a member of the 22-man committee who was selected to represent chiropractic, the second-largest healing art, the healing profession which generated the heat which caused Congress to ask for the study in the first place. If the AMA had picked the committee from Chicago (and we have little reason to believe they didn't), they couldn't have weighted it more heavily in favor of a continuing medical monopoly of Medicare.

But then, maybe I'm overly sensitive about this matter of fair representation on committees. I'll list the 22 members and their affiliations, if known, at this point in my report. If you think I have been prematurely harsh in my judgment, write and tell me. If not; you had better write your Representative and tell him what you feel the chances are of an unbiased report coming from this kind of a committee.

The Ad Hoc Consultant Group members are:

1. Chairman: Mr. Frank Bane, Washington, D.C.
2. Mr. Nelson H. Cruikshank, Washington, D.C.
3. Mr. Fred C. Diamond, President, Hillhaven, Inc., Tacoma, Washington.
4. Mr. Howard Ennes, Second Vice President and Director of Community Health Services of the Equitable Life Assurance Society of the U.S., New York.
5. A. R. Foley, M.D., Chairman, Department of Psychiatry, The Catholic Medical Center of Brooklyn and Queens, Inc., New York.
6. Mr. James M. C. Haughton, First Deputy Administrator, Health Services Administration, City of New York.
7. Mr. Teld T. Holmes, Administrator, North Carolina Baptist Hospital, North Carolina.
8. Jack Kleh, M.D., Washington, D.C.
9. Leslie Knott, M.D., Los Gatos, California.
10. Margaret D. Lewis, Director, Visiting Nurse Association, Denver, Colorado.

11. Darrel J. Mase, Ph.D., Dean, College of Health Related Professions, University of Florida, Gainsville, Florida.
12. Nagi Saad, Ph.D., Department of Sociology, Ohio State University, Columbus, Ohio.
13. Senator Maurine B. Neuberger, Chairman, Citizens Advisory Council on Status of Woman, Department of Labor, Washington, D.C.
14. Mr. Walter Newburgher, President, Congress of Senior Citizens.
15. Mr. Sam Pollack, President, Meat Cutters District Union 427, AFL-CIO, Cleveland, Ohio.
16. Ernest W. Saward, M.D., Medical Director, Kaiser Foundation Hospitals, Beth Kaiser Hospital, Portland, Oregon.
17. William Selden, Ph.D., Princeton, New Jersey.
18. William A. Spencer, M. D., Director, Texas Institute for Rehabilitation and Research, Houston, Texas.
19. William B. Strong, D.O., New York, N.Y.
20. Robert Westlake, M.D., Syracuse, New York.
21. Sidney Silverman, D.D.S., Professor and Chairman, Department of Graduate and Postgraduate Prosthodontics, College of Dentistry, New York University, New York.
22. Floyd D. McNaughton, Arlington, Virginia.

I wish to emphasize that my criticism here is of the structure of the committee, not of any individual member (except, possibly, the chairman). But I wouldn't expect a group of Catholics to bring back an unbiased report about Protestants and vice versa. Nor would I expect the Republicans to make a fair, objective report about the Democrats. I certainly do not believe a medically dominated committee structured like the above can bring back a report which will be seriously considered by Congress.

The president-elect of the American Medical Association, Dr. Gerald D. Dorman, was quoted in the New York Post on November 7 as saying that "changes may be enacted by the new Congress in the Medicare program for the aged, including an expansion of qualified health providers to groups such as chiropractors . . . ."

Obviously, the president-elect of the AMA knows the temper of Congress. We think we do, too. And we don't think Congress will put up with this kind of shenanigans from HEW.

Statement on Behalf of the National Health Federation, by Charles Orlando Pratt, Washington General Counsel

Your witness, Charles Orlando Pratt, respectfully presents this statement on behalf of The National Health Federation, 211 West Colorado Boulevard, Monrovia, California 91016, a non-stock, non-profit California Corporation, which is devoted to health matters and the cause of freedom of choice in health care, provided such choice does not interfere with the health and welfare of others.

Throughout America it is apparent that the limited number of medical doctors cannot adequately care for all the citizens who need health care.

Medical doctors, because of the patient demand, are developing so-called physician multipliers or physician assistants. In general, these are persons trained as nurses—not necessarily even registered or graduate nurses. For example, such persons with limited training function by counseling, diagnosing and prescribing for patients in both health and disease. Some of these trainees or nurse-trained persons are involved in the role of being a physician multiplier. They are sometimes called health professionals. They are used because there are not enough medical doctors to care for the aged or other patients.

Licensed doctors of chiropractic are professionally trained in the basic sciences as are doctors of medicine. The extent and scope of the educational requirements of one qualified to practice chiropractic are well known to this Committee. It is the second largest healing arts profession in America today.

The professional services of doctors of chiropractice are needed now, not to supplant doctors of medicine but to supplement them, because doctors of medicine are too few and too over-burdened.

The National Health Federation urges Congress to amend the Social Security Act so that the citizens of the United States, who use the care of doctors of chiropractic licensed in their states, shall be entitled to all the benefits of the program of supplementary medical insurance for the aged.

The Federation believes that Congress should not make any law which will abridge the privileges or immunities of citizens of the United States in health care.

The Federation believes that Congress should not deprive any person of the liberty to choose his or her own kind of health care from, and by, a duly licensed doctor of chiropractic.

The Federation believes that the citizens of the United States and the doctors of chiropractic, duly licensed by the state in which they practice, should not be denied by Congress the equal protection of the laws of the United States by denying them the benefits of the Social Security Act.

The Federation believes that the absence of a provision in the Social Security Act providing for payments for chiropractic services, under the program of supplementary medical insurance benefits for the aged, may, in truth and in fact, constitute an unconstitutional, and an unlawful abridgment of the privileges and immunities of citizens of the United States. Such denial does deprive the citizen of his property right and liberty to choose and use the healing arts care, which he believes is, or will be, most beneficial to him. Such denial does, indeed, deny the United States citizen the equal protection of the federal health laws.

The Federation believes that the freedom of choice in health care is an inalienable right, which is necessary to secure the blessings of liberty and to promote the general welfare in health matters.

The citizens who are patients of doctors of chiropractic, and the said doctors, are tax-paying citizens. Their taxes are used to pay for health and medical care and facilities under the Social Security Act. The use of this health care and of these facilities is denied the patients of the doctors of chiropractic; and thereby, their rights and privileges are denied.

The medical and allied professions, for whose services Congress has provided payment under the program of supplementary medical insurance benefits for the aged, may not be able to do the whole job of protecting the health and welfare of the United States citizens, because millions of Americans do not use or want drugs unless required by law.

Millions of Americans are justifiably afraid to use the powerful drugs, antibiotics and medicines on the market today, because of the repeated public revelation by the government, the press, radio and television, that such products have dangerous, serious and sometimes deadly side effects. These citizens, therefore, want to have available to them the professional advice and care of licensed doctors engaged in the healing arts professions, who do not recommend or use in their practice such products.

Congress should do justice to all United States citizens by providing for the use of federal tax revenues, under the provisions of the Social Security Act, to pay for the health services of patients of doctors of chiropractic duly licensed under state law.

Patients of doctors of chiropractic should have the same and equal right to have federal assistance in paying their health bills as do the patients of the other healing arts professions. These citizens should not be deprived of federal assistance.

American citizens should not be compelled, directly or indirectly, to be cared for, or treated, according to a majority opinion on health care.

America has grown strong by protecting minority rights against the overwhelming power and influence of the majority. This principle applies as much today in the need to protect the minority rights of the patients of the chiropractic doctor as it applies to protect the minority rights in religious or civil rights fields.

Congress should do no less than to protect the minority privileges and immunities of all Americans who need and want health care from the chiropractic profession.

Congress should do no less than to guarantee to all patients of doctors of chiropractic the equal protection of the Social Security Act. The best interests of the government and of the people will be served thereby.

STATEMENT ON BEHALF OF THE NATIONAL ASSOCIATION OF NATUROPATHIC PHYSICIANS, BY CHARLES ORLANDO PRATT, WASHINGTON GENERAL COUNSEL

Your witness, Charles Orlando Pratt, respectfully presents this Statement on behalf of the National Association of Naturopathic Physicians, 1920 North Kilpatrick Street, Portland, Oregon 97217, which is devoted to the cause of strength-

ening and conserving public health through the philosophy, art, science, and practice of naturopathy.

The Association urges Congress to amend the Social Security Act so that the American citizens, using the care of doctors of naturopathy licensed in their states, shall be entitled to all the benefits of the program of supplementary medical insurance for the aged.

The Association believes Congress should make no law which abridges privileges or immunities of United States citizens in health care. The power of medical majority opinion could open the way for crushing verdicts that may stifle minority ideas in health care at the expense of the public welfare and the aged citizens.

The Association believes United States citizens and licensed doctors of naturopathy should not be denied by Congress equal protection of the laws by denying them the benefits of the Social Security Act.

Throughout America it is apparent the limited number of medical doctors cannot adequately care for all the citizens who need health care.

Medical doctors, because of the patient demand, are developing so-called physician multipliers or physician assistants. In general, these are people trained as nurses—not necessarily even registered or graduate nurses. For example, such people with limited training function by counseling, diagnosing and prescribing for patients in both health and disease. Some of these trainees or nurse-trained people are involved in the role of being a physician multiplier. They are sometimes called health professionals. They are used because there is not enough medical doctors to care for the aged or other patients.

The professional services of doctors of naturopathy are needed now, not to supplant doctors of medicine but to supplement them, because doctors of medicine are too few and too over-burdened.

Medical and allied professions, for whose services Congress has provided payment of supplementary medical insurance benefits for the aged, may not be able to do the whole job of protecting the health and welfare of the people, because millions of Americans do not use or want drugs unless required by law.

Millions of Americans are justifiably afraid to use the powerful drugs, antibiotics and medicines on the market today, because of the repeated public revelation by government, press, radio and television that such products have dangerous, serious and sometimes deadly side effects. These citizens, therefore, want to have available to them the professional advice and care of licensed doctors engaged in the healing arts professions who do not recommend or use such products.

American citizens should not be compelled, directly or indirectly, to be cared for, or treated, according to a majority opinion on health care.

The Association believes Congress should not deprive anyone the liberty to choose his kind of health care from, and by, a licensed doctor of naturopathy.

The Association believes freedom of choice in health care is an inalienable right, which is necessary to secure the blessings of liberty and to promote the general welfare in health matters.

Patients of Naturopathic Physicians and the physicians are tax-paying citizens. Their taxes are used to pay for health and medical care and facilities under the Social Security Act. The use of this health care and these facilities are denied patients of Naturopathic Physicians; and, thereby, their rights and privileges are denied.

Congress should do justice to all citizens by providing for the use of federal tax revenues under the provisions of the Social Security Act to pay for the health services of patients of doctors of naturopathy duly licensed under state law. Such license is as valid as one for a doctor of medicine.

Patients of Naturopathic Physicians should have the same and equal right to have federal assistance in paying their health bills as do the patients of the other healing arts professions. These citizens should not be deprived of federal help.

The Association believes the absence of a provision in the Social Security Act providing for payments for the services of Naturopathic Physicians, under the program of supplementary medical insurance benefits for aged, may constitute, in truth and in fact, an unconstitutional and an unlawful abridgement of the privileges and immunities of citizens of the United States. Such denial does deprive the citizen of his property right and liberty to choose and use the healing arts care, which he believes is or will be most beneficial to him. Such denial does, indeed, deny the United States citizen the equal protection of the federal health laws.

The Association believes that Congress should not make any law which will abridge the privileges or immunities of citizens of the United States in health care.

America has grown strong by protecting minority rights against the overwhelming power and influence of the majority. This principle applies as much today in the need to protect minority rights of the patients of the Naturopathic Physician as it applies to protect minority rights in religion or civil liberties.

Congress should do no less than to protect the minority privileges and immunities of all Americans who need and want health care from Naturopathic Physicians.

Congress should do no less than to guarantee to all patients of doctors of naturopathy the equal protection of the Social Security Act. The best interests of the government and of the people will be served thereby.

NATIONAL ASSOCIATION OF NATUROPATHIC PHYSICIANS,
Portland, Oreg., September 10, 1970.

Hon. TOM VAIL,
Chief Counsel, Senate Finance Committee,
New Senate Office Building, Washington, D.C.

DEAR MR. VAIL: At the request of Mr. Charles Orlando Pratt, Washington General Counsel for the National Association of Naturopathic Physicians, the following brief, respecting naturopathic medicine is being submitted to the Senate Finance Committee for study during the forthcoming hearings on H.R. 17550.

The brief was prepared by the National Association of Naturopathic Physicians at the request of the Department of Health, Education and Welfare in 1968, for use in its study to determine the feasibility of including the services of licensed practitioners performing health services in independent practice (Part B of Title XVIII of the Social Security Act).

At the present time the licensed professions of chiropractic and naturopathy are not included within the framework of the Social Security Act. Counsequently, the elderly citizens of the United States who desire health-care service other than that offered by orthodox medicine are denied such service unless they pay for the privilege out of meager pension funds or personal savings.

According to reliable reports by various agencies, there is a tangible lack of licensed health-care practitioners to adequately care for the health needs of our ever increasing community of elderly people.

The National Association of Naturopathic Physicians feels that the inclusion of *ALL licensed* practitioners in the Supplementary Medical Insurance program would be of considerable help in closing the gap that now exists in health-care delivery because of the evident lack of trained personnel.

The inclusion of *ALL licensed* purveyors of health-care service in the Social Security Act should not entail any increase in cost to the program since they offer *alternative* service rather than *additional* service.

The NANP is appreciative of this opportunity to present our case to the committee.

Sincerely,

J. W. NOBLE, N.D.

NATIONAL ASSOCIATION OF NATUROPATHIC PHYSICIANS—OUTLINE FOR STUDY OF SERVICES OF PRACTITIONERS PERFORMING HEALTH SERVICES IN INDEPENDENT PRACTICE

I. ORGANIZATION: NATIONAL ASSOCIATION OF NATUROPATHIC PHYSICIANS

A. STRUCTURE

1. Historical development

Naturopathic medicine embraces several state and national bodies, plus a semi-active international organization.

The national history of naturopathic organization runs through varied names, title and leadership—all concerned with what has been virtually the same basic on-going association.

The present National Association of Naturopathic Physicians was formed in 1956 by merging two foregoing groups—the American Naturopathic Association and the American Association of Naturopathic Physicians. The present N.A.A.P. is today's single most comprehensive naturopathic society, albeit there is a relatively inactive International Society of Naturopathic Physicians.

Headquarters of the National Association of Naturopathic Physicians is at 1920 North Kilpatrick, Portland, Oregon 97217. Its President is John W. Noble, N.D. Arno Koegler, N.D., of 22 McDougall Avenue, Waterloo, Ontario, Canada, is President of the International Society of Naturopathic Physicians.

2. Official purpose

The N.A.N.P. exists to strengthen and conserve public health through the philosophy, art, science, and practice of naturopathy (see Article II of the appended Constitution of the N.A.N.P.)

3. Regional, state, and local affiliations

Article I of the appended N.A.N.P. By-Laws authorizes the affiliation with N.A.N.P. of local associations under these conditions:

> Section 1. Any state or territorial association wishing to become a constituent association of the National Association of Naturopathic Physicians shall make application on a prescribed form and submit evidence that its Constitution By-Laws, and Code of Ethics conform generally to those of this Association.
>
> Section 2. It shall be a condition of such affiliation on the part of the constituent associations that the work of the officers, boards, departments, councils, bureaus, and committees of this Association will receive the cooperation of the constituent associations through their corresponding agencies.
>
> Section 3. It shall be the duty of the Executive Committee to investigate and act upon all applications for affiliation as constituent associations, and pursuant thereto it may issue a charter to those whose Constitution, By-Laws, Code of Ethics, and general plan of operation conform in substance with those of this Association. The Executive Committee shall not issue more than one charter within the same state or territory.

There are at present formal state associations affiliated with the N.A.N.P. in Oregon, Idaho, Washington, Kansas, New York, Connecticut, and California.

4. Sources of income

N.A.N.P. income is derived from membership dues, paid annually—($12 for each member of a local association and $20 for each individual (non-member of a local association) N.A.N.P. member): from educational seminars, and from proceeds from conventions when such meetings realize a profit. Currently, N.A.N.P. is planning publication of a professional journal and its advertising profits will revert to the N.A.N.P. treasury.

5. Staff

N.A.N.P. does not maintain a paid staff. Its elected officers perform its organizational work. They are a President, Vice-President, Immediate Past-President, Treasurer, and Secretary—comprising the N.A.N.P. Executive Committee, plus nine Trustees, also elected. These two groups of officials comprise the administrative (policy-making) and judicial (disciplinary) executive echelon of the Association.

The current officers are:

President: John W. Noble, N.D., 1920 North Kilpatrick, Portland, Oregon 97217.

Vice-President: John B. Bastyr, N.D. 735 10th. Avenue, E., Seattle Washington 98102.

Immediate Past-President: Douglas E. McArthur, N.D., Seaboard Building, Seattle, Washington 98100.

Treasurer: Henry Linke, N.D., 320 Main Street, Kellogg, Idaho 83837.

Secretary: Dorothy Johnstone, N.D., 6005 S.W. Capitol Highway, Portland, Oregon 97201.

Trustees are:

Arizona:

Michael Lunch, N.D., 15 Leroux, Flagstaff, Arizona 86001.

Donald R. Bettner, N.D., 1137 W. McDowell Road, Phoenix, Arizona 85006.

Colorado: Robert E. Bock, N.D., Box 61, Monte Vista, Colorado 81144.

Idaho:

Wendell M. Grout, N.D., 827 Main Avenue, W., Twin Falls, Idaho 83301.

A. J. Hahn, N.D., 710 S. Orchard, Boise, Idaho 83705.

Indiana: F. C. Albrecht, N.D., 627 S. Main Street, Crown Point, Indiana 46307.

Oregon: Charles R. Stone, N.D., 304 Postal Building, Portland, Oregon 97204.

Washington:

Walter Adams, N.D., 412 E. 72nd Street, Seattle, Washington 98115.

Robert V. Carroll, N.D., 318 Shafer Building, Seattle, Washington 98101.

The officers named above will serve through mid-August, 1968. The Trustees serve three-year, staggered terms, with three seats becoming vacant and subject to being filled electively each year during voting at the annual N.A.N.P. convention.

Qualifications for holding the above-named offices will be found in Articles V and VI of the appended N.A.N.P. Constitution.

6. Membership

a. Individual members

Members of the N.A.N.P. and its affiliated associations are licensed naturopathic physicians—N.D.'s: or dually-licensed naturopathic physicians and chiropractors—holding both N.D. and D.C. degrees: or chiropractic physicians practicing in states which do not license naturopathic physicians per se—practitioners who nonetheless diagnose and treat patients under the principles of naturopathic medicine, hence meet the membership standards of N.A.N.P. In several states without licensing statutes pertinent to naturopathy, naturopathic physicians are registered, thereby again obliging membership standards of N.A.N.P.

In reciting membership statistics, we should emphasize that this questionnaire is not being completed and filed solely on behalf of practitioners who are N.A.N.P. members. Rather, it is aimed at advancing arguments for and defining the professional posture of *all* men and women who practice as naturopathic physicians in the United States.

It is estimated that there are in the United States, under the three above-cited conditions of practice, 3,000–4,000 practicing naturopathic physicians. Because of the varying conditions affecting licensure, regulation, registration, or the common law right to practice, we cannot offer a precise head-count, but we believe that the total number of active and inactive naturopathic practitioners in the United States today would break down in approximately these numbers:

New England	350
Middle and southern Atlantic coast	650
Chicago-Great Lakes area	600
Southern middle west	750
Southwest, including California	1,500
Northwest	850
Total	4,700

Current (mid-1968) membership of N.A.N.P. by state association breaks down this way:

Oregon	20
Washington	26
Idaho	26
Kansas	16
New York	7
Connecticut	24
California	17
Individual members, not affiliated with a local association	32
Total	168

(Canadian membership is not included, as these practitioners would obviously not be concerned with applications of U.S. laws.)

b. Individual membership qualifications

Continuing the points made as a necessary prelude to answering I.A.6.a., above, naturopathic physicians are specifically licensed or registered in fourteen states and the District of Columbia: licensed in Washington, Oregon, Arizona, Utah, Florida, Connecticut, Hawaii, Virginia, Ohio, Pennsylvania, and the District of Columbia; registered in California, North Carolina, New York, and Kansas (and practicing under common law in Idaho).

Most states with licensing statutes require two years of pre-naturopathic college in liberal arts or science. In addition, all states require four-year, in-residence study in an approved naturopathic institution, with a total classroom instruction of 4500 hours (a median figure—requirements range from 4000–4800 hours).

(Parenthetically, by defining requirements for licensure or registration, we are also definining requirements for membership in the N.A.N.P., the questionnaire's specific point of inquiry.)

Many state have enacted statutes requiring that applicants must pass a basic science examination administered by the particular state's Board of Higher Education before being examined by a naturopathic examining board.

In states with no specific naturopathic licensing laws, most often registries of practitioners are maintained. . . . registration under some other type or term of licensure, or without any license in some cases. Registries exist in states in which there is no formal N.A.N.P.-affiliated association. States which now maintain such registries include California, New York, Kansas, and North Carolina. . . . to our knowledge. We have appended California's registry as a sample.

The most succinct body of data on naturopathic licensing is contained in "State Licensing of Health Occupations", U.S. Department of Health, Education & Welfare, Public Health Service, National Center for Health Statistics—Public Health Service Publication No. 1758, of October, 1967; pp. 61, 62, 63.

To become a fully qualified, active member of N.A.N.P., a practitioner must meet membership requirements set forth in the appended N.A.N.P. By-Laws; Article II and III.

Associate members of N.A.N.P. are those persons without a Doctor of Naturopathy degree but who carry on natural healing activities within the limits of state and federal law. Acceptance (most often via state registry) of persons in this category does not confer a degree or license upon the individual, obviously, but acknowledges and affirms the legality of the work they are doing and records their practice statistically. Among the N.A.N.P.'s associate members (by registry) are many chiropractors and physiotherapists, most of whom work closely with naturopathic physicians.

c. Dues

See Article III of the appended N.A.N.P. By-Laws.

B. ACTIVITIES

1. Approved programs

Licensing and/or registration as a naturopathic physician by entities of government have been described in the above I.A.6.a. and b.

Regarding approval for membership in the N.A.N.P. and/or its affiliated associations, Article I of the appended By-Laws contains the stipulation that no state association or society or chapter (whatever its nomenclature) shall be accepted for N.A.N.P. membership unless the applying group makes application on an N.A.N.P.-prescribed form or submits other evidence that its own membership requirements, Constitution, By-Laws, and Code of Ethics conform generally to those of N.A.N.P.

It follows that individual practitioners or applicants for associate membership must likewise agree to conform to N.A.N.P.'s stipulated guidlines for professional conduct.

a. Personal members

Single practioners must meet the minimal membership requirements of local N.A.N.P.-affiliated chapters, whose membership criteria must in turn meet N.A.N.P. conditions.

Members of N.A.N.P. are subject to the same re-approval of their membership as licensed practitioners are subject to suspension-of-license or revocation procedures in states with licensing statutes N.A.N.P. and its affiliated chapters

maintain intra-professional boards or committees empowered to hear public grievances and/or intra-naturopathic grievances against practitioners who violate the profession's state or national organizational Codes of Ethics. Likewise, state boards of examiners or other licensing or administrative agencies are empowered to review, suspend, revoke, and/or renew naturopathic licenses.

The N.A.N.P.'s current Code of Ethics, adopted in 1960, is appended.

b. Health care institutions

Naturopathy is primarily a single-practitioner profession. Some practitioners share practice with a colleague; a few have initiated specialized clinical practices (which were common prior to World War II). Because naturopathic physicians predominately treat patients in their offices or in patients' homes albeit many rest and convalescent homes admit naturopaths to care for patients in those facilities), no N.A.N.P. screening of institutions has been initiated. There are no solely-endowed naturopathic hospitals or similar facilities, hence criteria for evaluating such facilities have not been developed.

c. Educational institutions

In major heading IV, to follow, this subject is dealt with more comprehensively.

At present, the sole active and approved four-year college for the study of naturopathy is the National College of Naturopathic Medicine, legally headquartered at 1920 North Kilpatrick, Portland, Oregon 97217, but presently conducting classwork at 1327 North 45th Street, Seattle, Washington 98103. The college's President is Maxwell H. Morris, Th.D., at the Seattle address. The President of the college's Board of Trustees is Fred Loffler, N.D., 175 East Broadway, Vancouver 10, British Columbia, Canada. The Registrar is George Rombough, N.D., at the Seattle address.

The College is approved by N.A.N.P. and the Canadian Naturopathic Association. It is approved for training veterans under Public Law 550 and is certified to educate eligible veterans under Oregon's Veterans' Aid Act. The U.S. Department of Immigration has placed the College on its list of colleges and universities approved for the admittance and education of foreign students. A diploma from the College is recognized by State boards of examiners in all licensing states, and in Canada.

Administrative control over the College is vested in an elected Board of Trustees and the College President, Dean, and faculty. The College is owned by the Naturopathic Physicians Educational Foundation, organized under Oregon law as a non-profit corporation.

Current President of the Foundation is B. A. Smith, N.D., 870 Garden Valley Blvd., Roseburg, Oregon. Current Secretary-Treasurer is Lloyd Rapp, N.D., 103 North Umpqua, Sutherlin, Oregon.

2. *Meetings*

N.A.N.P. calls and holds annual membership meetings, at times and places set by its Executive Committee or as determined by membership vote at the prior annual meeting.

Component chapters of N.A.N.P. likewise host educational seminars and/or meetings are identical: to promulgate organizational policy and stimulate post-Naturopathic Physicians Convention of May 9–11, 1968, the program for which is appended.

The purposes of both regional-local and national naturopathic membership meetings are identical: to promulgate organizational policy and stimulate postgraduate education.

Attendance is open to any bona fide member of N.A.N.P. or its affiliated local chapters.

Seminar or speech topics at such meetings range from legal-medical to intra- and inter-professional; i.e., legal responsibilities of naturopaths to their patients, research results or practice innovations from allied health care professions, new therapeutic techniques, new botanical medicines and their application, etc.

3. *Research*

a. Intramural

Not having a specific research facility, naturopathy does not pursue research as an organized collective. A primary reason for the lack of collective research is under-financing; i.e., grants-in-aid and other private foundation or government funds are not being made available to this profession.

Individual practitioners and graduate students have been and are currently working in the fields of physiotherapy, nutrition, and botanical medicine . . . particularly in relation to the management of chronically ill and geriatric patients. Likewise, N.A.N.P. committees on technique evaluation, physiotherapy analysis, and the management of orthopedic problems are currently at work in conjunction with faculty of the National College of Naturopathic Medicine.

b. Extramural

Possibly much of the research we refer to above falls into the category "Extramural" . . . as being "outside . . . the walls . . . of an organized unit" (to cite Webster's definition).

In essence, the N.A.N.P. nurtures and encourages research, but cannot finance it on its own. N.A.N.P. can and does recognize intra-professional research by soliciting monographs for its seminars and for the publication "The Naturopath", which will be described more fully below.

a. Purpose

The N.A.N.P. is currently completing plans for publication of a quarterly "Journal of Naturopathic Medicine," to be first printed in early 1969, for members and the interested lay public.

Currently, "The Naturopath" is published as an instrument to circulate professional research papers by member and non-member naturopaths, news of botanical medicines and their application, and general news pertinent to health care fields allied with or germane to naturopathy.

b. Circulation

Published monthly, "The Naturopath" reaches more than 5000 doctors (alopathy, chiropractic, osteopathy, and naturopathy) and laymen. It was first published in 1962 and its most recent edition prior to this report was August, 1968.

5. Copy of the current publication list

Copies of the last 12 editions of "The Naturopath" are appended.

C. ASSOCIATION RELATIONSHIP WITH OTHER HEALTH PRACTITIONERS

1. Joint activities

In every instance where their cooperation has been solicited, the N.A.N.P. and its affiliated chapters have joined with, met with, or otherwise shared with other health care professions their body of technical knowledge.

A case in point, where formal interrelationships were involved, was the Oregon Interprofessional Health Council. In this instance, the Oregon Association of Naturopathic Physicians was a founding agency of this group, which was formed for the mutual exchange of healing arts knowledge. Naturopathy joined podiatry, chiropractic, pharmacy, veterinary medicine, osteopathy, and optometry to create the Council.

The N.A.N.P. works with every type of health care practitioner in legislative matters, urging the upgrading of all professions' standards by self-discipline and/or state or federal statute. In the several states where its chapters are operative, or in Washington, D.C. at the federal level, N.A.N.P. has worked closely with departments of welfare, industrial workmen's compensation boards, private and public rehabilitation agencies, boards of health, and other entities which deal with comprehensive health care.

Naturopathy's keenest immediate concern is with diet and nutrition, therefore the parent Association and its component chapters and members seek close relationships with dieticians, nursing in general, nutritionists, food chemists, organic chemists, botanists, horticulturists, and others concerned with man's basic sustenance: food.

2. Policies and activities endorsed

Organized naturopathy supports pure food and drug laws and their enforcement, the complete and free dissemination to all practitioners of newly-discovered techniques of treatment, and maximum inter-professional referral of patients when the specialty of an allied profession is called for.

N.A.N.P. has strongly endorsed federally endowed health care programs and equivalent private group plans. In 1961, N.A.N.P. relayed to then-President

John Kennedy its unqualified endorsement of "Medicare-Medicaid" (either King-Anderson or Kerr-Mills).

N.A.N.P. endorses strongly the F.D.A. stand on "dangerous drugs" and supports state legislatures, moves to curtail their unrestricted dispensing and use. The Association supports the concept of increased federal aid to health-care students and the institutions which educate them. The Association supports efforts to lower the price of remedial substances generally, especially for geriatric patients and pensioners.

3. Policies and activities not endorsed

N.A.N.P. opposes "fad" healing and quackery, but it likewise opposes the F.D.A. attitude concerning food supplements . . . proposals which would confine certain types of food supplements to a presciption basis. The Association is organically (i.e., "naturally") directed—therefore it opposes over-use of toxic fertilizers and other chemicals which taint our foodstuffs and which harm our national ecology and individual health.

N.A.N.P. opposes, intra-professionally, criticism of other health care professions, unprofessional advertising or conduct by its members, and racial or religious discrimination among patients.

D. CODE OF ETHICS

The N.A.N.P. Code of Ethics is appended.

1. Official association statement

The appended Code of Ethics carries within it a set of policy statements which sum-up official attitudes of the N.A.N.P.

2. Describe disciplinary procedures

Grievances or actions against practitioners can originate with (1) state boards of examiners; (2) other state regulatory authorities (where naturopathy is not licensed per se); (3) committees or governing boards of affiliated chapters of N.A.N.P., or (4) with the governing officers of N.A.N.P. itself.

In the case of the first two groups of bodies cited, suspension or revocation of a practitioner's license or legal ability to practice will also result in the N.A.N.P.'s voiding a practitioners membership. Results of such action by agencies of government are usually forwarded to either the affiliated chapter's officers or to N.A.N.P. itself where there is no local chapter.

Within an affiliated chapter, such grievances are heard, testimony of the aggrieved party is solicited and heard, statements by the accused practitioner are heard, and a decision is rendered.

Intra-professionally, an "aggrieved person" can be a fellow naturopathic practitioner, a practitioner in an allied health care field, an officer of N.A.N.P. or an affiliated chapter, or a layman at large.

Some disciplinary matters are not appealed to the N.A.N.P., and others come before only the N.A.N.P. (where a practitioner is an N.A.N.P. members but in a state with no local chapter). N.A.N.P. is, however, bound to suspend or expel a member whom tthe lower, affiliated chapter has found guilty of professional misconduct, or whom a Board of Examiners has adjudged guilty. Likewise, a practitioner suspended or expelled by N.A.N.P. will not be eligible for membership in any local chapter unless and until he or she is re-accepted for membership by N.A.N.P.

Disciplinary matters can be routed from N.A.N.P. to a local society, or from a local society to N.A.N.P.—depending upon who makes the accusation and the membership status of the accused. In all instances whether either the national or a state association originates the disciplinary hearings, the results of those hearings—if culminating in expulsion or suspension—are forwarded to state boards of examiners or other regulatory authorities for their consideration and action.

II. THE DISCIPLINE

A. DEFINITION

The Dictionary of Occupational Titles, U.S. Department of Labor, Washington, D.C., defines naturopathy as follows: Doctor, Naturopathic (medical service), 0-52-21. Naturopathic. A healer. Diagnoses and treats patients to stimulate

and restore natural bodily processes and functions, using a system of practice that employs physical, mechanical, chemical, and psychological methods; utilizes dietetics, exercise, manipulation, chemical substances naturally found in or produced by living bodies, and the healing properties of air, light, water, heat, and electricity. Provides for care of bodily functions, processes, or traumas, and treats nervous or muscular tensions, abnormalities of tissues, organs, muscles, joints, bones, and skin, pressure on nerves, blood vessels, and lymphatics, and assists patient in making adjustments of a mental and emotional nature. Naturopathy excludes the use of major surgery, X-ray, and radium for therapeutic purposes and the use of drugs with the exception of those substances which are assimilable, contain elements or compounds which are components of bodily tissues and are useable by body processes for maintenance of life.

Webster's Seventh New Collegiate Dictionary (G. & C. Merriam Company, 1965), on page 563, defines naturopathy as: a system of treatment of disease emphasizing assistance to nature and including the use of natural medicinal substances and physical means (as manipulation and electrical treatment).

In his book "Basic Naturopathy" (1948, American Naturopathic Association, Inc.), Harry Riley Spitler, N.D., M.D., Ph.D., uses this definition: Naturopathy is a complete system of practice, making use of nature's agencies, forces, and processes, and products for therapeutic purposes, exclusive of major surgery.

The definition adopted by N.A.N.P. is this: Naturopathy (naturopathic medicine)—A system of treatment of human disease which emphasizes assisting nature. It embraces minor surgery and the use of nature's agents, forces, processes, and products, and introduces them to the human body by any means that will produce health-yielding results.

B. THE SCIENTIFIC BASIS OF NATUROPATHY

1. Historical development

One aspect of Naturopathy dates to the pre-Christian Egyptians—to their use of massage and manipulation of the body, its muscles, its tissues: the beginning of mechanotherapy. The Old Testament refers to subsequent Israelite rules governing diet hygiene. The steam and vapor baths (early hydrotherapy) of middle Europe in the Middle Ages still obtain as does the use of cold and hot baths perfected by early Romans and Athenians.

The herbal, botanical side of naturopathy dates most clearly to the Chinese of 5,000 years ago, the discoverers of therapeutic value in ginseng, cascara, and other roots, flowers, and botanical substances.

Naturopathic education dates to the Athenian teachings of Easculapius during the 13th century B.C. Of the 300 "healing centers" in Greece which followed, 200–300 years B.C., one (at Kos) nurtured Hippocrates, father of modern medicine.

In 1050 A.D. the first "university of hygiene" was founded at Salerno, Italy: the initial book of health rules it produced went through 240 editions.

As the 12th century opened, universities were founded in Bologna, Montpellier, and Oxford. Paracelsus began experiments with the body's dependency upon sulphur, mercury, and salt, and with the concept of internal medication . . . giving birth to the theory of iatro-chemistry, the forerunner of contemporary pharmacology.

It could be held that naturopathy as a formal profession and discipline was recognized and legalized when the "Herbalist Charter" of King Henry VIII was enacted by Englands Parliament. That document read in part: Be it ordained, established, and enacted, by authority of this present Parliament, That all Time from henceforth it shall be lawful to every Person being the King's subject, having Knowledge and Experience of the Nature of Herbs, Roots, and Waters or of the Operation of the same, by Speculation or Practice, within any part of the Realm of England, or within any other of the King's Dominations, to practice, use, and minister in and to any outward Sore, Uncome Wound, Aspotemations, outward Swelling or Disease, any Herb or Herbs, Ointments, Baths, Pultess, and Emplaisters, according to their cunning, Experience, and Knowledge in any of the Diseases, Sores, and Maladies beforesaid, and all other like to the same, or Drinks for the Stone, Strangury, or Agues, without suit, vexation, trouble, penalty, or loss of their goods. . . .

Hydrotherapy, as an adjunct of natural healing, gained initial European prominence through the movement begun by Priessnitz at his institute in Grafenberg, Silesia in 1829. At first, lay patients, and later physicians, sought his teaching and help with such practical procedures as plunge, hot and cold packs, sitz baths, and compresses.

But hydrotherapy is only one of the many therapeutic techniques employed by naturopathy. Rickli delved into sunlight and air cures following Priessnitz' lead, beginning in 1848. Berg began research into vegetarian diet; Finsen, into ultraviolet treatment; Coue, into psychology; Schroch into warm moisture, dry diet, and fasting . . . all precursor scientists to the formal regimen of today's naturopathy.

The groundwork for naturopathy per se was laid by Hippocrates, when he wrote in a treatise on "Epidemic Diseases"—"Nature is the healer of all disease. Let foods be your Medicine and your Medicine your Foods."

The 19th century . . . from 1859 to 1900 particularly . . . fleshed-out Hippocrates' basic thesis. Man after man added to the body of knowledge concerning natural healing: Christian was the food scientist; Buckley was the first American physician to recognize the value of diet in treating cancer patients; Wilstatter, a German chemist, was first to study the healing properties of chlorophyll in treating anemia.

The 20th century practitioner who tied all the foregoing body of knowledge together, into the formal concepts of contemporary naturopathy, was Benedict Lust, born and educated in Germany, who introduced naturopathic healing to the United States in 1892, with the founding of his Yungborn Health Institution in New Jersey. . . . at the same time that Dr. Still propounded the philosophy of osteopathy and Dr. Palmer inaugurated the practice of chiropractic.

Naturopathy's pioneers, in addition to Lust, included Kellogg, founder of the Batle Creek Sanitarium, and Hahnemann, founder of homeopathy.

2. *Scientific theories and principles*

Naturopathy (naturopathic medicine) is the technique of treatment of human disease which emphasizes assisting nature. It can embrace minor surgery and the use of nature's agencies, forces, processes, and products, introducing them to the human body by any means that will produce health-yielding results.

Naturopathy is based upon the tendency of the body to maintain a balance and to heal itself. The purpose of naturopathic medicine is to further this process by using natural remedies . . . as distinct from "orthodox" medicine (allopathy and osteopathy), which seeks to combat disease by using remedies which are chosen to destroy the causative agent or which produce effects different from those produced by the disease treated (from the definition of "allopathy"—Webster's Seventh New College Dictionary: 1965: p. 24).

Naturopathy places priority upon these conditions as the bases for ill health: (1) lowered vitality; (2) abnormal composition of blood and lymph; (3) maladjustment of muscles, ligaments, bones, and neurotropic disturbances; (4) accumulation of waste matter and poison in the system; (5) germs, bacteria, and parasites which invade the body and flourish because of toxic states which may provide optimum conditions for their flourishing; (6) consideration of hereditary influences, and (7) psychological disturbances.

In applying naturopathic principles to healing, the practitioner may administer one or more of specified physiological, mechanical, nutritional, manual, phytotherapeutic, or animal devices or substances. The practitioner's end aim is to remove obstacles to the body's normal functioning, applying natural forces to restore its recuperative facilities. Only those preparations and doses which act in harmony with the body economy are utilized, to alter perverse functions, cleanse body of its catabolic wastes, and promote its anabolic processes.

3. *Supportive studies and research*

Bibliographies containing reference works used in teaching undergraduate practitioners-to-be, and utilized, postgraduate, by practicing naturopathic physicians, are appended hereto, from the Library of Congress and from the National Library of Medicine in Bethesda, Maryland.

In sum, the texts on these appended bibliographies comprise the primary body of formal knowledge which governs the practice of naturopathy—the results of research emanating from or pertinent to this profession, and case studies which confirm the validity of the naturopathic mode of practice.

C. THE PRACTICE OF NATUROPATHY

1. Role of diagnosis

Diagnosis (as defined by Gould and as accepted by naturopathy) is the determination of the nature of a disease by—

Anatomical diagnosis: diagnosis based upon the recognition of definite anatomical alterations lying back of the phenomena;
Post-mortem diagnosis: diagnosis made after death, by autopsy;
Clinical diagnosis: diagnosis made from the symptoms alone;
Differential diagnosis: distinguishing between two diseases of similar character by comparing their symptoms;
Exclusion diagnosis: recognition of a disease by excluding all other known conditions;
Pathological diagnosis: diagnosis of the structural lesions present in a disease;
Physical diagnosis: determination of disease by inspection, palpation, percussion, or auscultation and observation;
Topographical diagnosis: that based upon the seat of a lesion.

Diagnosis is, necessarily, each physician's prelude to prescription and/or treatment, as it is with all naturopathic physicians, albeit that diagnosis from verbal (orally-given) symptoms, is unacceptable. Naturopathy's forebearers may have set today's standards for diagnosis as a mandatory prelude to treatment. The chemist of George Washington's era, Carl Wilhelm Scheele, discarded from his apothecary shop the previously (and automatically) applied "iron from the nails of the coffins of criminals," etc., as essential medications." Further symptoms alone are but one phase of diagnosis, for symptoms are to naturopathy, as Hippocrates wrote, "Partly symptoms of defense and partly symptoms of failure."

a. Interview

Techniques for patient interviews are generally consistent throughout naturopathic practice. Sample questionnaire forms for completion by physician and/or patient are appended. The personal interview is the naturopathic physician's first phase of diagnosis—observation, visual detection of obvious abnormalities of a physical or psychological character, aural detection of physiological (speech) or psychological abnormalities, etc.

During the interview, the naturopathic physician examines extensively for subjective symptoms which are revealed through conversation, and seeks maximum objective or subjective information following the diagnostic outline in 1. above.

b. Physical examination

Guidelines in the diagnostic outline of 1. above apply to physical examination of the patient as well as to aural-written notions.

Initial physical examinations, for new patients, are comprehensive, regardless of the nature of the patient's complaint—to establish history and ascertain with some exactitude the current status of the patient's body. Manual and visual examination of the body—its limbs, muscles, orifices, is routine.

The naturopath applies to his physical examinations of patients the principles in which he has been trained—osteology, Roentgenology, dermatology, syndesmology, myology, neurology, topographical anatomy, ophthalmology, angiology, physiology, otalaryngology, clinical psychology, pediatrics, proctology, gynecology, obstetrics, etc.

Aside from data collected on a patient's questionnaire, the physical examination probes functions of the neuron and muscle fibers and their interdependence in myoneural action; physio-chemical phenomena associated in the process of osmosis, diffusion, and their bearing on such functions as pulmonary and cellular respiration, absorption, and secretion; the physiology of the heart, blood, and lymph; the excretory functions of the kidney (see following d.), skin, and lungs; the endocrine system and its role in the metabolic process; the function of the cerebrospinal and autonomous nervous systems; the physiology of the male and female generative systems.

c. Diagnostic aids

The narturopath's armamentarium includes every accepted diagnostic instrument: Sphygmomanometer; stethoscope, electro-cardiograph; endo-cardiograph; thermometer; speculums; proctoscopes; sigmoidoscopes; instruments for testing

reflexes, aural receptivity, and for testing pressure of the eyeball; scales; X-ray fluoroscopes—the gamut of modern medicine's diagnostic equipment. (Note: naturopathic physicians utilize X-ray for diagnostic purposes, *not for therapy.*)

d. Laboratory tests

The naturopathic physician is schooled in inorganic chemistry, bio-chemistry, biology, zoology, histology, microscopic anatomy, splanchology, embryology, bacteriology, pathology, toxicolgy, trophology, endocrinology, etc.

He is trained in laboratory diagnosis, conducting his own tests or utilizing state health department or private laboratories for studies and evaluation. (A sample report form utilized by Oregon's Public Health Laboratory in reporting test results to naturopaths is appended.) The naturopath applies physiological and pathological chemistry to his analyses: micro-biology and micro-bacteriology, serology, and bio-chemistry.

All of the bodies' tissues, fluids and excretions are subject to examination during the course of laboratory testing as part of naturopathic diagnosis: urine, sputum, feces, epidermal abnormalities, gastric fluids, etc.

Blood testing, aside from its role as part of any general physical examination, is also conducted by the naturopath for the specific purpose of detecting venereal disease or as a concomitant and pre- and post-natal care and the prophylaxis of or informational reporting on new-born infants. Serology is an essential part of naturopaths' geriatric and gerontological practice.

2. Treatment methods

Obviously, treatment will vary with the condition which necessitates it. Generally speaking, naturopathy utilizes nature's agencies, forces, processes, and products, which may be applied to the body by using physiotherapy, mechanotherapy, or hydrotherapy. Botanical agents and biological remedies may be prescribed, for external application or internal consumption, and nutritional counseling may figure in treatment.

Iontophoresis is employed frequently to ionize certain remedies in the treatment of disease when it is deemed inadvisable to prescribe internal medication.

Naturopathy's overriding dictate . . . when the practitioner's decision to apply prophylactic or physiological therapeusis is being formulated . . . is that nature is a sensitive agent possessing the faculty of making her own cures.

The techniques applicable to naturopathic treatment of disease and illness are the same techniques applicable to treatment by an allopath, with greater emphasis upon hydrotherapy, massage, manipulation, or electrotherapy in necessary instances, and with greater utilization of medications in their natural or botanical form than in their chemically-created or derived form.

To draw a simple comparison, naturopathic gynecology and obstetrics parallel allopathic gynecology and obstetrics. Naturopathy's osteopathic treatment embraces the identical principles of clinical visceral neurology and orthopedics (minor surgery) as those guiding the osteopath. Similarly, naturopathy's uses of Roentgenology and radiology are no more radical than those of allopathy.

Naturopathy does, in general, rely less heavily on radical alteration of bodily functions and chemistry than do other healing arts. Naturopathy's primary stresses include light therapy (helio, light, ultra-violet, infra-red, chrome, etc.); electrotherapy (galvanic, faradic, sinusoidal, diathermic etc.); vigrotherapy (oscillations, concussions, vibration, spondylotherapy); remedial exercies (kinesiotherapy, medical gymnastics, body mechanics, active and passive exercise); manipulations (osseus and soft tissue, mobilization and immobilization techniques, spinal therapy, manipulative and orificial surgery); vasomotor control; mechanical therapy (utilizing supporters, prosthetics, belts, casts, pneumatotherapy, zone therapy, orthopedic devices); crymotherapy; biochemic therapy (nutritional—correcting deficiencies and employing corrective or hygienic nutrition, phyotherapy—using naturopathic botanicals, herbal, and vegetable materials as listed in "Naturae Medicina"; the use of tissue minerals and cell salts—Schuessler, vitamins, endocrines, etc.; vaportherapy; colon therapy—irrigating agents and other products for the treatment pathoses of this region; autotherapies; climatotherapy.

3. Patient records

Refer to appended, sample patient interview (narrative case history) questionnaires and laboratory reports. Each practitioner maintains his own form of on-going record for detailing a patient's medical history or progress.

D. CONTRIBUTIONS OF NATUROPATHY TO THE HEALTH FIELD

1. New knowledge

See the appended bibliography of works utilized as references by this profession. These lists include works which are the product of naturopathic case studies or research.

Naturopathy's contribution to the formal, published body of medical research is limited because almost all of its practitioners are individuals, without the benefit of teaching hospitals, numerous clinics, or other study centers in which pure research—endowed privately or by government—can be conducted. Naturopathy's research is confined primarily to monographs printed in its professional publications or delivered orally at its conventions and other educational meetings.

Many naturopathic physicians feel that their profession's principles are still untried by the larger body of allopathic medicine, hence various naturopathic principles which are centuries old could still be considered "new" to the contemporary practitioner who has yet to utilize them in the late 20th century.

2. New techniques

Essentially, the answer to D. 1. above applies to this question, save that naturopathic undergraduate and postgraduate teaching and seminar curricula embrace every new concept, technique, medication, and instrument which becomes known to the healing arts generally (and which is within legal limitations upon naturopathic practice).

3. New approaches to health

Here it can be held without contradiction that naturopathy has led the way in the fields of nutrition, dietetics, metabolic chemistry, and in some areas of hydro- and physiotherapy. For example, long established naturopathic principles were given national esteem 25 years ago through the "Sister Kenny treatment" for poliomyelitis. Naturopathy's manipulative techniques have been substantially emulated by chiropractic. Naturopaths and their 19th-century forebears were the first to recognize validity in the hypnosis thesis of Paracelsus, Cagliostro, von Helmont, Mesmer, and Braid. Naturopaths, in Freud's professional infancy, were already attuned to the value of psychotherapy.

Less dramatic than citing the naturopathic origins of new "truths" in 20th-century healing, but nonetheless illustrative of naturopathy's ever-modern approach to health, is a recitation of some of the current curricula at its National College of Naturopathic Medicine: applied psychology, suggestotherapy, autosuggestion, therapeutic hypnotism, occupational therapeutics, psychosomatic therapy—are examples of naturopathy's academic currency.

III. PRACTITIONER

A. TOTAL MANPOWER

1. National

a. Age

The average age of today's naturopathic physician is 51.

b. Sex

Presently, about 90% of America's naturopathic physicians are male; 10% female.

c. Active and inactive

The precise number of inactive practitioners is not known. It is estimated that there are between 500–700 active and inactive naturopaths in those states with specific licensing or regulatory statutes or procedures, and an additional 3000–4000 active and inactive practitioners in states where naturopathic practice is conducted under common law.

2. States, per 100,000 population

There are approximately 2.2–2.5 naturopathic physicians per 100,000 people in the United States today.

B. ASSOCIATION MEMBERS

1. National

a. Age

The same median age of 51 years applies to members as well as non-members.

b. Sex

The same (90% female) breakdown applies to members as to non-members.

c. Active and inactive

Active (practicing) members, approximately, 95 percent.
Inactive (non-practicing) members, 5 percent.

2. States, per 100,000 population

In the seven states where there are N.A.N.P.-affiliated chapters or associations, the ratio of member practioners to each 100,000 of that state's population would be approximately: Oregon, 1.1; Washington, .9 ; Idaho, 3.7 ; Kansas, .7 ; New York, .04 ; Connecticut, .96 ; California, .1.

In states containing practitioners not associated with a local association, but nonetheless active N.A.N.P. members (32 in Nevada, Colorado, and Arizona), the median ratio of practitioner-per-100,000 population within the entire tri-state area would be .9.

C. USUAL LOCATION OF PRACTICE OR ACTIVITY

1. General or short-stay hospitals

N.A.N.P. has no knowledge of any specifically naturopathic hospital in the United States, although there are hospitals operated by religious orders, private trusts, non-profit organizations or corporations, or by other healing arts professions to which naturopathic patients (and naturopathic physicians) are admitted on par with other patients and practitioners.

Where naturopaths are admitted to such hospitals, and where naturopaths utilize minor surgery, such surgery is conducted in accordance with legal limitations upon naturopathic practitioners, and/or in accordance with the particular hospital's staff rules.

2. Specialty or long-stay hospitals

As stated above, N.A.N.P. knows of none.

3. Other inpatient institutions

A substantial number of such facilities—primarily rest and convalescent homes—admit patients under naturopathic care on par with all other patients.

4. Outpatient facilities

Ambulance services, clinics (school and private), patients' homes, practitioners' offices, rehabilitation centers—are available to and utilized by naturopathic physicians.

5. Agencies and organizations

As contributing members of the national health-care fraternity, naturopathic physicians confer with the lend counsel to such entities (as an example) as Oregon's Advisory Board to its State Board of Health and the Oregon Inter-professional Health Council previously described. Naturopaths can and do minister to welfare recipients, to recipients of industrial accident insurance benefits, etc. Naturopaths are available as practitioners and clinicians to any entity of local, state, or federal government which wishes to employ their talents.

In such facilities as the National College of Naturopathic Medicine, outpatients are treated by practitioners and their students on a clinical basis.

D. TYPES OF PRACTITIONERS; GENERAL AND SPECIALITIES

1. Scope of practice

Naturopaths work within specific statutory limits, which usually prohibit major surgery and the administration of narcotics. Such statutes are not only

acceptable to naturopathy but, in some instances, have been engendered by naturopathy, which believes—as one case in point—that major surgery is a highly limited, highly specialized field of medical service which, when necessary, should be performed by those allopathic practitioners who devote most of their time to that art.

Because naturopathy is by root a natural mode of healing, the restrictions against administration of narcotics are welcomed and encouraged by naturopaths.

Naturopaths have no aversion to referring. Naturopathy's educational curricula is inclusive of most elements of allopathy, but naturopathic practitioners utilize this training *diagnostically* in large part, referring extensively to allopaths or more specialized practitioners (podiatrists, optometrists, dentists, chiropractors, etc.) where initial diagnosis dictates or where subsequent therapy is unfruitful or where symptoms remain unabated under purely naturopathic therapy.

As an example of statutory limitations upon this profession, the salient Oregon law governing naturopathy is appended.

Roughly 90% of today's naturopathic physicians are in general practice; 10% specialize—in pediatrics, obstetrics, gynecology, proctology, dermatology, chiropractic, etc.

2. Size of practice

The average naturopathic practitioner serves a patient population of 2000 yearly.

3. Limitations of practice

D. 1., above, touches this subject, as do the appended Oregon licensing statutes (as sample statutory language). "Limit" and "scope" of practice are in a sense synonymous.

Naturopaths in the main serve geriatric patinets, by choice, not fiat. Naturopathic rights extend from pre-natal care (and subsequent obstetrics), through the detection and reporting of contagion, to signing birth and death certificates. Naturopaths are prohibited from performing major surgery, but can perform minor surgery.

Intermingling this answer with that to D.1. above, naturopaths can and do diagnose, apply naturopathic therapy to, and thereby treat, acute infectious disease and abnormalities of the digestive system, the respiratory system, the cardiovascular system, the urinary system, the hemopoetic system, the nervous system, and the endocrine system.

The only weapons they cannot bring to bear upon conditions within this systemic list are major surgery, the prescription of narcotics, and the administration of radiation therapeutically.

Additionally, because of hospital rules in most instances not law, naturopaths are limited in (or restricted from) practicing in general hospitals. Therefore, when there is need for specialized care within the confines of a hospital, the naturopath—of procedural necessity—most often refers to an appropriate practitioner admissable to such hospitals.

4. Practice conducted on authorization or under supervision of another health care practitioner

Naturopaths do not practice as "technicians" for allopaths or any other practitioners. In general, they practice independently of supervision—neither their diagnoses nor their therapy nor prescribed medications are subject to review (by law or protocol) by any other practitioners. Naturopaths refer extensively. This has been dealt with in prior answers, and to the extent that the specialist and the naturopath who referred a patient to him may confer on continuing diagnoses or treatment, there is consultation and cooperation, but not implied or actual supervision by one doctor over another.

5. What percent of service is given in independent practice

100% of most naturopathic practice is devoted to individual patients, on a non-clinical basis. If the question refers to modes of payment for individuals' treatment, it is estimated that 80% of all naturopathic patients are personally responsible for their physicians' billings; 20% are "Medicaid", welfare, industrial accident, or private-public insurance carrier benefit recipients.

E. RELATIONSHIPS TO OTHER HEALTH CARE PRACTITIONERS

1. All patients

a. To allopaths, chiropractors, other naturopaths, optometrists, podiatrists, osteopaths, dentists, pharmacists, nurses

(*1*) *Who refers.*—The naturopathic physician.

(*2*) *Why.*—When the naturopathic physician feels that specialized attention is in the best interest of the patient.

The appended N.A.N.P. Code of Ethics touches upon referral in several ways. Articles I, Section 7 states that the "naturopathic physician may decline to attend a patient when he deems the treatment required is beyond the scope of his license"; Article I, Section 8 states that "The naturopathic physician shall act upon the desire of the patient for consultation or if he deems his art, skill, or experience inadequate, he shall advise consultation"; Article III, Section 2 states that "The attending physician shall give the case history and laboratory and clinical findings to the consulting physician".

b. From other naturopathic physicians, chiropractors, optometrists, podiatrists, osteopaths, allopaths, nurses, dentists, and pharmacists

(*1*) *To whom referred.*—The naturopathic physician.

(*2*) *Why.*—Re-referral of an originally-naturopathic patient, when the specialist's course of treatment (or major surgery) is concluded, or when the natural healing techniques of naturopathy are indicated as most potentially beneficial, or, lacking a specific, when the best interest of the patient would be so served (or when the patient himself requests such consultation or referral).

2. Consultation

a. Given by any of the practitioners named in 1.a. and b. above.

(*1*) *Who requests.*—The patient, his attending naturopath, or a member of another healing arts profession who is either a family retainer or who has been called upon by the patient or the attending naturopath.

(*2*) *Why.*—As recited in 1. a. and b. above, primarily, because of the best interest of the patient.

b. Requested by the patient, the attending naturopathic physician, or a member of another health care profession

(*1*) *Who provides.*—Any of the practitioners named in 1. a. and b. above.

(*2*) *Why.*—More extensive diagnosis is indicated or a specialist's particular attention is desired.

F. MAJOR PROBLEMS PRESENTED BY PATIENTS TO PRACTITIONER

1. All patients

Patients under 40 years of age account for the highest percentage of acute, illnesses and infections, trauma, and musculo-skeletal problems. Problems affecting patients over 40 but under 65 are more or less chronic in character.

2. Patients 65 and over

More geriatric/gerontological in nature, the problems of the lderly are progressively chronic as age advances, and are primarily cardio-vascular or respiratory and are generally degenerative.

G. ACTIVITIES OTHER THAN DIRECT PATIENT CARE

Teaching is of necessity confined to those practitioners headquartered near the National College of Naturopathic Medicine—in the Pacific Northwest: 30 licensed naturopaths currently serve as full- or part-time faculty members at the College, with the ranks of Assistant or Associate Professor, X-Ray Technician, and Clinical Laboratory Technologist.

Six naturopaths hold full Professorships at the College; college administration is handled by a staff including five naturopaths, and eight naturopaths comprise the College's rank of officers and trustees.

Naturopaths serve on state boards of examiners and other licensing or regulatory bodies administering their own or allied professions.

Naturopaths report contagious and infectious diseases to their respective departments of health; issue birth and death certificates; serve on formal or informal interprofessional health councils; support food chemistry and nutritional research.

II. RELATIONSHIP WITH THIRD-PARTY PAYERS

1. Federal programs

Naturopathy's involvement is not consistent state-to-state, depending upon the number of practitioners and status of the profession in a given state, and depending upon the state's degree of implementation of federal programs requiring matching state participation. In Oregon, for instance, naturopaths are included in the coverage provisions of Title XIX—"Medicaid" (Chapter 502, Oregon laws, 1967; ORS 414.025, Section 3. In Bremerton, Washington, another case in point, naturopaths' services to U.S. Navy personnel are paid for federally.

2. Blue Cross

Payments to naturopaths from Blue Cross-affiliated societies or corporations have been limited to emergency diagnostic procedures and laboratory work.

3. Blue Shield

The above answer to II.2. applies here.

4. Commercial insurance companies

Many private carriers honor naturopathic billings, in whole or in specified (within varying policy limits) part, among them Standard Insurance Co., Mutual of Omaha, Continental Casualty Co., Bankers Life & Casualty, Monarch Life, and New York Life—all of which pay for naturopathic services *in full.*

5. Consumer-sponsored organizations

Some trade union-sponsored health care plans honor naturopathic billings. The profession, to our knowledge, does not deal through any other consumer-sponsored third-party payers at this time.

IV. EDUCATION

A. ACCREDITATION PROCEDURE FOR SCHOOLS OF TRAINING PROGRAMS

1. Accreditation only

As described in detail in the appended "Directives to Council on Education and Syllabus of Minimum Curriculum for the Guidance of Accredited Naturopathic Colleges", three bodies adopted the current accreditation standards for naturopathic institutions of higher learning—the profession's Council on Education, the Council on State Boards of Naturopathic Examiners, and the House of Delegates of the American (now National) Association of Naturopathic Physicians. Their action was taken in July, 1953.

Membership of the Council on Education comprises representatives of currently or provisionally accredited schools and an equivalent representation from the general body of practicing naturopaths, the latter being named by the Board of Trustees of N.A.N.P. The Council on State Boards of Naturopathic Examiners comprises representatives from each state maintaining such a licensing and examining body. The House of Delegates of the N.A.N.P. is the national Association's primary policy-making body of delegate members from states in which it has individual members or affiliated local associations.

Applications for accreditation are reviewed by the three above-named groups, either in concert or singly (i.e., the House of Delegates normally convenes only during annual N.A.N.P. conventions).

(Note: As has been recited earlier, the National College of Naturopathic Medicine is the single active teaching facility in the United States at present, although N.A.N.P. is informed that the former Sierra States University, 1413 7th Street, Santa Monica, California, may be in the process of reorganization and may seek re-accreditation. In Canada (we note this because of the cross-border character of naturopathy, whose practitioners' credentials are virtually identical through-

out North America), the Institut de Naturopathie du Quebec, 150 Ouest Laurier, Montreal, Quebec, Canada—Raymond Barbeau, Director, has applied for accreditation and its courses have been approved for the purpose of transferring credits to United States naturopathic facilities.)

2. Process of accreditation

Application must be made concurrently to the three approval bodies described above in A. 1., and approval must be forthcoming from all three bodies. For further detail, see the appended Syllabus. pp. 1–4.

3. Accreditation requirements

See the attached Syllabus.

a. Curriculum

See attached Syllabus and appended course catalog for the National College of Naturopathic Medicine.

(1) Courses

(*a*) *Subject matter.*—See the attached Syllabus and course catalog.
(*b*) *Hours per course.*—See the attached Syllabus and course catalog.
(*c*) *Texts.*—See the attached catalog. Supplementary textural matter—documents not required to be in student possession, are on library loan. See the appended bibliographies of naturopathic reference works for sample titles.

(2) Course hours

(*a*) *Academic: number and percent.*—3618 hours required; 77.33% of total required course hours.
(*b*) *Clinical: number and percent.*—1088 hours required; 22.67% of total required course hours.
Outpatient training.—No hospital facilities are available for outpatient training.
Hospital training.—See above answer.
For other clinical training, see the answer to IV. A.3.a.(2).(b), above.
(*c*) *Internship or field training.*—Students receive practical experience in the National College of Naturopathic Medicine's clinic, in the College building, at 1327 North 45th Street, Seattle Washington 98103, and through externship in the offices of various faculty member naturopaths.

Externships and clinical assignments are based upon a student's need and prior experience. Thus, an experienced chiropractor entering the College as a senior-year student would not be placed in the office of a specialist in osteology, nor a former obstetrical nurse or midwife placed with an obstetrics specialist. All students, however, are required to spend 80 hours in obstetrical internship and to aid in two or more deliveries.

(3) Grading systems

See attached course catalog.
(*a*) (*a. was omitted on questionnaire*)
(*b*) *Entrance qualifications.* See attached course catalog and Syllabus.

c. Faculty

(1) Qualifications

See attached course catalog and Syllabus. The N.C.N.M. faculty is largely volunteer; practitioners from British Columbia, Washington, and Oregon. Many have Bachelors degrees; all have N.D. degrees and are licensed to practice. The College President holds B.S., M.A., and Th. D. degrees; the clinical nurse holds B.S. and R.N. degrees. (Note: The faculty of the Institut de Naturopathie du Quebec is equally qualified; see appended photocopy of page 4 of the Institute's catalog.)

(2) Number students per faculty member

A condition of accreditation is that the College shall maintain at least one faculty member per 25 students. Because of the diverse number of academic subjects in the College's curricula, and the over-all faculty size (30-plus), there are considerably less than 25 students working with one teacher at any given time.

d. Physical plant

The N.C.N.M. building is at 1327 North 45th Street, Seattle, Washington, where most classes and clinical training in naturopathic medicine are conducted. The building was purchased in May, 1964, for $45,000, has since been remodeled, and is now valued in excess of $50,000. The building contains a fully-equipped clinic, administrative offices, and two classrooms on its lower (ground) floor, and one classroom and three living quarters on its second floor. Current planning calls for transforming the living-quarter space to additional classrooms, a laboratory, and a dissecting room.

(1) Laboratories

The College contains one laboratory, operated in conjunction with its clinic. Remodeled and refurbished in the spring of 1968, this laboratory is equipped and utilized for conducting clinical testing, but is too small for extensive research.

(2) Libraries

The N.C.N.M. maintains a 5000-volume library, most of its works dealing with natural drugs—older books whose content remains unchanged by any but radical research innovation. Because of the relatively static character of naturopathic publishing, the library remains valid and is more adequate than the sheer number of volumes would imply.

(3) Clinical facilities

The student clinic at the Seattle College building has adequate facilities and modalities for all of naturopathic practice except obstetrics. Space is limited, however, to four students working there at any given time; students therefore rotate between days in the clinic and externships in various professional offices within the greater Seattle area, on an assigned, pre-arranged basis, according to student needs and preferences.

e. Postgraduate education program

Formal postgraduate work offered by the National College of Naturopathic Medicine has been limited to instruction necessary for graduates of predecessor colleges (which required only 4000 hours of classroom teaching) to reach the 4400- to 4800-hour level now required for practice in many states. N.C.N.M. has not initiated course work toward the Ph.D. degree, nor residencies toward specialization, because of inadequate research facilities. The College is working presently on a program to equip itself to offer a Ph.D. in nutrition.

Informal postgraduate educational work, to keep naturopathic practitioners abreast of developments in their own field, as well as in general medicine, includes:

(1) International and national association conventions

At least one 8-hour day during each such convention is devoted to discussion and consideration of recent developments in naturopathic science.

(2) Joint Northwest regional naturopathic conventions

Once a year, practitioners from Oregon, Washington, Idaho, British Columbia, Alberta, Saskatchewan, and other northwest areas convene in one of these states or provinces to share new knowledge. Speakers are also invited, from other professions (see appended 1968 N.N.P.C. program) to conduct seminars; usually 20 hours of each such meeting are devoted to professional postgraduate education.

(3) State meetings

Where there is an N.A.N.P.-affiliated state association, or where registries of practitioners are maintained, these formal or informal groups of naturopaths hold meetings at intervals which vary from state to state (but no less than once annually) during which at least one half-day is devoted to educational programs.

(4) Seminars

In the Pacific Northwest, the College in Seattle and area-wide local associations sponsor a monthly series of week-end professional education seminars. These seminars usually occupy all of Saturday afternoon and evening, and Sunday morning. They vary in content from simple demonstrations in the use or operation of new modalities (such as newer types of electrocardiographs, sphygmomanometers, electro-therapy apparatus, etc.) to technical training in such subjects as proctology, otolaryngology, obstetrics, etc.

Students of the National College of Naturopathic Medicine are admitted to such seminars, but receive no course credits for attendance. The N.C.N.M. does grant one-quarter-hour of post graduate course credit for attendance to those naturopaths who are currently also engaged in extensive and pre-arranged reading courses on the subject at hand.

Note: The current tendency among naturopathic licensing and regulatory boards is to seek legislation to make a required number of annual postgraduate study hours mandatory by law as a prerequisite to re-licensing. N.A.N.P. is encouraging not only expanded postgraduate education but the concept of making it mandatory for all practitioners. (See sample proposed Oregon law.)

B. TRENDS IN EDUCATION

Perhaps the early history of the now-dormant Sierra States University mentioned in IV.A.1. above portends the practical and probable direction of future naturopathic education.

Sierra States, chartered in California in 1921, maintained colleges in naturopathy, chiropractic, physical therapy, psychology, and allied subjects. During its existence in San Francisco, from 1921–1950 (it moved to Los Angeles in 1950, then to its present Santa Monica location), Sierra States graduated probably 1000 practitioners in the various healing arts for which it was authorized to issue degrees. During its 1950–1961 period in Los Angeles, Sierra States graduated 200 naturopath/chiropractors.

The National College of Naturopathic Medicine is suffering from a dearth of students—as are many private liberal arts colleges and universities, and most private and public colleges and universities graduating allopathic physicians, optometrists, dentists, etc. Potential student interest in the healing arts is at the same low ebb among all health care professions. Student bodies are very often not commensurate with the size of the teaching facilities maintained to educate them. Recruiting must become more aggressive (see D. to follow).

Our point is that it may now be apropos for increased mergers of various colleges and universities currently devoted to single arms of the healing arts, into more workable, economically feasible teaching entities.

To that end, naturopathy is conducting inquiries among private liberal arts, business, theological, and health care-dedicated Pacific Northwest universities and colleges to determine their interest in merger with N.C.N.M. It would be premature to reveal the exact nature of these negotiations or the precise identities of the educational institutions involved.

It is hoped that such a resultant institution—headquartered on one campus in either Oregon or Washington—could and would serve students primarily from throughout the western United States and Canada, but affording equal entree to students from the remainder of the U.S. and Canada.

N.C.N.M. foresees no drastic changes in its current curricula, except for the addition of postgraduate courses leading to higher degrees than the N.D. (a merged university as described above, parenthetically, could take a student through his requisite pre-naturopathic undergraduate years' to a B.S. or B.A. if he desired, then through an N.D. degree, and subsequently through an M.S. or Ph.D. degree—on one campus).

Obviously it follows that, if postgraduate-level education is achievable on the basis described above, massively increased naturopathic research will follow, utilizing the clinical and laboratory facilities which must attend postgraduate teaching and which do not now exist in adequate proportion at N.C.N.M.

Merger or not, N.C.N.M. plans—as described in IV.A.3.d. above—to increase the physical size of its laboratory-clinic space in the near future, and plans to strengthen its postgraduate curricula. The moves in several states to make postgraduate education mandatory (as described in IV.A.3.e.(4). above) can work to the benefit of N.C.N.M., which is the most logical entity to devise continuous postgraduate educational courses, provide the faculty to teach them, and to sponsor and conduct such classes wherever and whenever they are taught throughout the United States, thereby also increasing the breadth of its undergraduate curriculum, its faculty's prowess, its income, and its general financial and professional stability.

Specific areas of curriculum change are difficult to forecast. The governing bodies of N.C.N.M. foresee increased stress upon the academies of diagnosis and treatment which are concerned with geriatrics and gerontology, and, conversely, with pediatrics. Diseases affecting both the elderly and the very young

are receiving primary research attention from America's healing arts today. Application of that research, to both prolong life and nurture new life, must occupy naturopathy's concern to an extent commensurate with that of allied health care professions.

Increased curricular stress upon chemistry and its multi-phases is also called for as medications grow more sophisticated (and potentially dangerous in some cases); increased attention to radiography and the effects or countering of radiation will likewise demand more curricular attention.

Naturopathy's most basic educational theses will become increasingly focused upon practical in-office, in-clinic, or in-home experience. Medicine's trend today, which naturopathy supports, is reversion to the "general practitioner" concept of healing—putting theoretical teaching in a less commanding perspective, in favor of "bedside psychology" and its person-to-person emphasis.

C. ENROLLMENT BY CLASSES SINCE 1960

Sierra States University, heretofore mentioned, and the Institut de Naturopathie du Quebec, have either not been appreciably operative since 1960—in the former instance, or the N.A.N.P. does not possess by-year enrollment statistics. in the latter case.

Here are data for the National College of Naturopathic Medicine:

Student capacity in (actual enrollment):

Year	Enrollment	Year	Enrollment
1960	6	1965	7
1961	6	1966	7
1962	7	1967	12
1963	13	1968	7
1964	9		

Number of graduates in:

Year	Graduates	Year	Graduates
1960	—	1965	2
1961	2	1966	—
1962	2	1967	4
1963	2	1968	3
1964	1		

D. RECRUITMENT TECHNIQUE OF SCHOOLS

N.C.N.M. has—with obviously adverse effect upon its enrollment over the years—let naturopathy's inducements virtually speak for themselves, through the mouths of zealot practitioners, when and where a convenient time to proslyte has arisen.

This almost tacit course of action cannot continue, as all other health care educators have found,

Therefore N.A.N.P. is embarking now, with and for N.C.N.M.'s aid and benefit, upon a program of distributing literature describing this profession, its educational facilities, and its prospects economically and socially as a career, to high school students, through their vocational counselors, local employment services, and faculty members teaching high school science courses.

Naturopaths are beginning to take advantage of "Business-Education Days" and/or "Career Days", in which high school students visit business or professional offices or plants, in fields in which they have expressed even tentative interest, to obtain exposure to these professions and analyze their career potentials.

Catalogs (as the appended N.C.N.M. course catalog), and pamphlets (as the appended "Brief Respecting Naturopathy in the United States"), and other literature documenting median practitioner income, areas where practitioners are especially needed, etc., are in the planning stage now by N.A.N.P. and N.C.N.M.

Special student tours to N.C.N.M. are being planned also, for the Pacific Northwest area, under N.A.N.P. auspices. Outside this geographic area, individual practitioners will be given kits of informational materials for direct contact with vocational counselors or for classroom or in-office presentations to students.

It is hoped, naturally, that federal aid can be obtained in time on the same basis that the Congress has dispensed aid to other health-care professions for building, research, short- and long-term student loans, and other operational costs, to assist naturopathy in its new recruiting program.

V. Title XVIII (Medicare)

A. Recommendations to the Congress for Changes in the Social Security Act to Broaden Health Coverage for People 65 or Over, and Priorities for Such Changes in Service

It is manifestly and abundantly apparent in America today that allopathy cannot by itself serve all of the nation's ill.

The stated or implied aim of allopthy to seek licensing latitude for creation of "medical technicians" to assist its licensed practitioners and thereby enlarge the scope of their practice in numbers of patients to be served is commendable.

But there are a number of distinct, licensed, and historically-rooted disciplines, among them naturopathic medicine, whose practitioners cannot and should not be subverted to the role of "medical technician."

Their patient load is substantial, albeit in some cases the number of their active practitioners may be actually or seemingly on the decline (due to the decline in student enrollment mentioned before).

Therefore, naturopathy would urge the Congress to allow the terms and conditions of Title XVIII to embrace all licensed healing arts; each of which would treat patients and be indemnified for so doing, *only within the scope of its licensed ability to do so;* i.e., there is no thought of encroachment upon the allopath's primary domain in naturopathy's attitudes or in this suggestion.

The priority for such inclusion is immediate; the practitioners—such as naturopaths—are *in* practice; they *are* treating patients; they will *continue* to do so, and for from atrophying, their self-educational and undergraduate educational programs are being revitalized to provide even more extensive service to the American public.

In sum, Title XVIII should be so amended as to allow complete "freedom of choice" by patients covered under the Act, of practitioner, location, type of treatment, etc. And such practitioners should be compensated on the same basis applicable to allopaths.

Naturopathy will not and does not advocate further philosophical changes in the Act; i.e., the N.A.N.P. does not advocate socialized medicine per se. It does advoacte equally inclusive treatment of all health-care practitioners, however, in all present or future Congressionally-enacted programs for federally subsidized or supervised group or individual health care.

B. What Is the Demand for the Services of Naturopathic Practitioners by Persons 65 or Over?

N.A.N.P. estimates that approximately 9,400,000 patients are being served currently, per year, by America's roughly 4700 licensed and/or/otherwise regulated naturopathic practitioners. Of that number, we estimate that 25% of the patients of naturopathic practitioners in general (vs. specialized) practice are 65 or older. Therefore, if the per-practitioner, per-year, median patient load is 2000, then 25% of each naturopath's patients (500 per year) fall into the 65-or-older age bracket.

C. Projection of the Future Needs of, and Demands for, the Services of Naturopathic Physicians by Persons 65 or Over—in 1975—in 1980

We are told that by 1975 roughly 50% of this nation's population will be 25 or younger. At the other end of the age spectrum, we forecast a significant yearly growth in the percentage of our population over 65. The healing, remedial, and generally life-prolonging product of geriatric and gerontological research and practice is vastly extended individual and collective longevity.

In spite of this increasing annual extension of our population's longevity, the ills of the elderly seem to remain primarily the same . . . mainly chronic, mainly cardio-vascular or respiratory, and generally degenerative. Naturopathy foresees no appreciable change in the *type* of abnormal conditions it encounters in elderly patients, in spite of their longer lives. The toxity of their excesses (alcohol, tobacco); the adverse changes in their ecology (air and water pollution) would indicate continuation of their afflictions at about the same level as today by the years 1975 or 1980. (Even the currently radical concepts of organic transplant, surgically, if eventually fully successful, can regenerate *only* the organ involved, and cannot effect therapy for the remainder of the patient's systems and organs.)

Therefore, naturopathy's needs for more teaching facilities, to produce more

practitioners, to care for a growing number of persons who comprise this profession's primary patient source . . . the elderly, must be envisioned as one of constant increase. Specific numbers are not practical to recite here. Even arithmetical ratios between the growing number of persons over 65 or to become over 65 and the naturopathic population which is extant or which should exist to serve them would be misleading: because we do not feel that, *today*, there are even a tenth of the necessary minimum number of naturopaths in practice in the United States. To extend this current equation would be faulty and a misleading understatement of potential public need for naturopathy's services.

Mr. PRATT. Thank you, Mr. Chairman. [Continues reading.]

In other words, we feel that the Congress has been denied access to the contents of the brief which took us almost six months to compile. We stand on the statement as originally drafted as nothing materially new has transpired since then to change its content.

Mounting evidence now exists that the gap between the application of professional skill and the urgent need for such service is more real than was suspected and it is the opinion of many interested citizens that the inclusion of other types of licensed practioners in the Supplementary Medical Insurance program of the Social Security Act would be of immediate benefit in bridging the gap.

According to the American Medical News for October 13, 1969, health manpower and health services are absolute top priorities in the health care field and Secretary Robert Finch of the Department of Health, Education and Welfare, is especially enthusiastic about using returning Vietnam medical corpsmen to augment the hard-pressed physician in reducing the serious shortage of doctors.

In a recent interview with reporters from the U.S. News & World Report of November 3, 1969, Dr. John A. D. Cooper, President, Association of American Medical Colleges, pointed out that President Nixon, in presenting a White House report on health-care needs, said there was a severe crisis in health-care delivery, and that part of this crisis was lack of an adequate number of physicians and other manpower in this field. President Nixon further stated that unless corrective measures are taken, we face a complete breakdown in the system in two or three years.

The National Association of Naturopathic Physicians feels that the inclusion of other types of licensed practitioners in the Social Security Act would help close the gap between the lack of skilled service and its application to the needs of the elderly citizen of the United States.

Since the minority groups in the health care field offer *alternative* service, rather than additional service, it is unlikely that the addition of these practitioners to the Social Security program would entail any additional cost to the administration of the program.

Your courtesy in considering our request is greatly appreciated.

This is signed by John W. Noble, N.D., president of the National Association of Naturopathic Physicians.

Mr. Chairman, would I have time to read a page and a half of my own statement.

The CHAIRMAN. Go right ahead.

Mr. PRATT. Which is similar to the one I prepared a week ago on behalf of another association from California.

Your witness, Charles Orlando Pratt, respectfully presents this statement on behalf of the National Association of Naturopathic Physicians, 1920 N. Kirkpatrick Street, Portland, Oregon 97217, which is devoted to the cause of strengthening and conserving public health through the philosophy, art, science, and practice of naturopathy.

The Association urges Congress to amend the Social Security Act so that the American citizens, using the care of doctors of naturopathy licensed in their states, shall be entitled to all the benefits of the program of supplementary medical insurance for the aged.

The Association believes Congress should make no law which abridges privileges or immunities of United States citizens in health care. The power of medical majority opinion could open the way for crushing verdicts that may stifle minority ideas in health care at the expense of the public welfare and the aged citizens.

The Association believes United States citizens and licensed doctors of naturopathy should not be denied by Congress equal protection of the laws by denying them the benefits of the Social Security Act.

The Association believes Congress should not deprive anyone the liberty to choose his kind of health care from, and by, a licensed doctor of naturopathy.

The Association believes the absence of a provision in the Social Security Act providing for payments for the services of Naturopathic Physicians, under the program of supplementary medical insurance benefits for the aged, may, in truth and in fact, constitute an unconstitutional, and an unlawful abridgement of the privileges and immunities of citizens of the United States. Such denial does deprive the citizen of his property right and liberty to choose and use the healing arts care which he believes is, or will, be, most beneficial to him. Such denial does, indeed, deny the United States citizen the equal protection of the Federal health laws.

The Association believes freedom of choice in health care is an inalienable right, which is necessary to secure the blessings of liberty and to promote the general welfare in health matters.

Patients of Naturopathic Physicians, and the physicians, are tax-paying citizens. Their taxes are used to pay for health and medical care and facilities under the Social Security Act. The use of this health care and these facilities is denied patients of Naturopathic Physicians; and, thereby, their rights and privileges are denied.

Medical and allied professions, for whose services Congress has provided payment of supplementary medical insurance benefits for the aged, may not be able to do the whole job of protecting the health and welfare of the citizens, because millions of Americans do not use or want drugs unless required by law.

And I mean required in connection with contagious diseases so as not to harm someone else.

Millions of Americans are justifiably afraid to use the powerful drugs, antibiotics and medicines on the market today, because of the repeated public revelation by government, press, radio and television, that such products have dangerous, serious and sometimes deadly side effects. These citizens, therefore, want to have available to them the professional advice and care of licensed doctors engaged in the healing arts professions, who do not recommend or use such products.

I might add here that these doctors are more or less sort of the practical side of Christian Scientists. They don't believe too much in using drugs. They would like to use a lot of natural foods and wholesome foods, and small as possible doses of any kind of drug on the market.

We all know that some 400 drugs are being recalled right now because of dangerous side effects of these drugs which have been on the market.

Congress should do justice to all citizens by providing for the use of Federal tax revenues, under the provisions of the Social Security Act, to pay for the health services of patients of doctors of naturopathy duly licensed under state law.

And I would like to point out that we are not asking for any help for any doctors not properly licensed under the State law.

Patients of Naturopathic Physicians should have the same and equal right to have federal assistance in paying their health bills as do the patients of the other healing arts professions. These citizens should not be deprived of federal help.

American citizens should not be compelled, directly or indirectly, to be cared for, or treated, according to a majority opinion on health care.

America has grown strong by protecting minority rights against the overwhelming power and influence of the majority. This principle applies as much today in the need to protect minority rights of the patients of the Naturopathic Physician as it applies to protect minority rights in religious or civil liberties.

Congress should do not less than to protect the minority privileges and immunities of all Americans who need and want health care from Naturopathic Physicians.

Congress should do not less than to guarantee to all patients of doctors of naturopathy the equal protection of the Social Security Act.

I mean doctors properly licensed by their States.

The best interests of the government and of the people will be served thereby.

Respectfully submitted, . . .

Mr. Chairman, this statement is respectfully submitted by the National Association of Naturopathic Physicians, by its Washington general counsel.

Thank you very much for your patience and your courtesy.

The CHAIRMAN. We thank you, Mr. Pratt, for coming to the committee.

Are there any questions?

If not, we thank you very much.

Mr. PRATT. Thank you, sir.
The CHAIRMAN. That completes the calendar for today.
Without objection, the committee will adjourn until Wednesday morning, November 12, at 10 o'clock.
(Whereupon, at 1:10 p.m., the committee adjourned, to reconvene at 10 a.m., on Wednesday, November 12, 1969.)

Senator ANDERSON. Miss Clare Blanchard.

STATEMENT OF MISS CLARE BLANCHARD, NATIONAL LEAGUE FOR NURSING, ACCOMPANIED BY MISS JANE KEELER

Miss BLANCHARD. Senator, I am Clare Blanchard. I am director of the Home Health Agency in Fairfield, Conn. Miss Jane Keeler of New Haven will present our testimony.

Miss KEELER. Mr. Chairman, my name is Jane Keeler, I am director of the Visiting Nurse Association, New Haven, Conn., a certified voluntary home health agency. I have been engaged in my profession of nursing for 28 years, 14 of these years have been spent in an administrative capacity, representing the Assembly of Home Health Agencies, Council of Public Health Nursing Services of the National League for Nursing. NLN is the national spokesman for 1,340 of the certified home health agencies throughout the country, and numbers in its membership the majority of the large community health agencies.

We refer to our agencies as "home health agencies," but our patients refer to us as "visiting nurses" or "community nurses." In the New Haven Visiting Nurse Association, we go to the patient's home to provide needed nursing and related services upon the patient's discharge from the hospital or when hospitalization is neither necessary nor desirable. Often, this means that we see our patients once or twice a week, to administer medication, change dressings, help with special diet planning, assess the patient's physical and emotional status and advise on how to cope best with the disabling conditions we often encounter. Of course, we see large numbers of the elderly who, without our efforts, would have to be in an institution. Many of these elderly citizens are proud, independent and self-respecting people. They have worked hard all their lives, and they don't want charity from anyone. They want to stay in their own homes, surrounded by the few possessions they treasure. For some, institutionalization would mean breaking their spirits. Some would deteriorate rapidly into senility. Others would die. And these tragedies would occur at much greater expense to the taxpayer than providing the needed services we are now giving to them: the visits of the nurse and/or physical therapist as well as the assistance of a home health aide, a woman supervised and trained by our staff who helps with meal preparation, baths, and other personal care.

Let me give you just one example of a patient situation, and this is an actual one. A Mr. John Doe, age 80, and Mrs. Doe, age 78, lived in a four-room, modestly furnished apartment. They had a monthly income of $195 per month from social security and a small pension and savings of $2,000. Their rent was $125 per month and the balance was used for meeting their other needs. Savings were gradually diminishing in amount. Mr. Doe experienced a stroke in October 1967. In January 1968, Mrs. Doe requested nursing service for her husband, noting that

she was exhausted from his constant care since he depended entirely on her for everything—frequently getting her up at night. The physician referred the patient to our home health agency rather than suggesting institutional care. The doctor indicated Mr. Doe's restorative potential as very limited. Based on the patient's needs and physician orders, the public health nurse planned with Mrs. Doe to visit the home three times a week.

The nurse realized very quickly that Mr. Doe had not been participating in his own care. Therefore, she began to encourage him to assist in his bathing and to move toward self-help activities. With the physician's approval, the physical therapist on our staff visited in the early part of the second week of agency service. Following this evaluation, physical therapy visits were made twice a week. The nurse continued visits three times a week for the next 5 weeks. After 3 weeks of service the patient was out of bed for short periods of time and had begun to read the paper and interact with visitors.

As the patient continued to progress, Mrs. Doe's fatigue and depression were greatly reduced and the general tensions observed in the home during early visits had greatly diminished.

The frequency of nurse and physical therapy visits were gradually reduced as Mr. Doe became more independent. At the end of 7 months he was up, out of bed most of the time, walking with a leg brace and cane, and was about 90 percent independent in all of his activities. At the end of 9 months, the Doe family was discharged from our service. The nurse later learned that this couple had moved to California and was living independently in a small apartment near their only son. Mrs. Doe sent several cards expressing her appreciation for all the help that she and her husband received; they counted it as a miracle.

This service given in 1968 was covered by plan B of medicare—the full cost was $785.

Today, with the present interpretation of medicare regulations by the SSA and fiscal intermediaries, Mr. Doe would not be eligible to have the cost of his care reimbursed through medicare. Present regulations prohibit payment to home health agencies for preventive health service and the care of patients with chronic illness who have a limited potential for rehabilitation. In the long run the cost to medicare or medicaid are increased substantially.

There are many elderly people who have slim prospects for total recovery, but who have the need for part-time intermittent skilled nursing observation, preventive and restorative services. Changes in the patient's physical or emotional condition may alternate between an acute and stable state, requiring observations, change in regimen, and medication. Denial of reimbursement for intermittent skilled nursing or therapeutic services to these individuals in their homes under the present regulation has, in many instances, forced their return to hospital or extended care facility at a much higher cost to the taxpayer.

The regulations under medicare have grown increasingly restrictive. In addition, fiscal intermediaries do not interpret the regulations uniformly throughout the country. The present regulations restrict reimbursement to acute phases of illness and do not provide for the health services needed to prevent regression of the patient. We do not believe that this is the intent of Congress.

Therefore, we ask the Congress to state clearly in the law the intent to include coverage of home health services necessary to prevent hospitalization.

We feel that many of the medicare provisions applying to home health agencies and the care that they provide should be improved. In the long run, it costs more, not only in human misery, but in hard cold cash to institutionalize our elderly citizens rather than caring for them and providing health services at home.

We agree with the view of HIBAC—the Health Insurance Benefits Advisory Council—and others who recommend enactment of legislation which would:

Place all home health benefits under part A, with a maximum eligibility of 200 visits per year;

Remove the 3-day hospital stay requirement for home health benefits; and in addition

Provide for coinsurance for the second 100 visits per year.

Every reasonable and necessary effort should be made to improve the quality of care given to patients. We therefore recommend that:

The utilization review process be extended to include home health services;

There be a requirement for involvement of public health nursing competence in the review of claims by fiscal intermediaries and by the Social Security Administration;

The law provide for the establishment of a Home Health Advisory Committee to assist the Department of HEW in the administration of its programs that involve home health agencies; and

The home health portions of medicare, medicaid, and maternal and child health programs, be coordinated by the Department of HEW.

In the interests of improving the quality of home health service, the National League for Nursing and the American Public Health Association provide for a national accreditation program of community nursing services. The criteria are more comprehensive than those required for certification in section 1861 (m) and (o) for home health agencies. We ask that section 1865 of Public Law 89–97 be amended to identify NLN–APHA as the national accreditation body for home health services.

It is the clear intent of H.R. 17550 to control costs by reducing the length of institutional care and increasing the amount of outpatient and home health services. NLN fully supports this objective.

To reduce inpatient care, further reduce hospital costs, and provide for coordinated care through early referrals to home health agencies, we recommend that home health agencies be permitted to employ home health service coordinators whose salaries would be fully reimbursable. Such coordinators would work with the physician, patient, and family to develop appropriate posthospital plans for the care of the patient.

To decrease costs and at the same time provide needed care for people, we suggest that program efforts be directed toward increased utilization of home health agency services. During the period of July 1, 1966–December 1967, home health agency costs accounted for only 1 percent of total medicare costs.

In addition, we support the recommendations of the staff of your committee in relation to the standardization and coordination of the

administration and provision of health care services under medicare, medicaid, and maternal and child health programs, as well as the staff recommendation that the Bureau of Health Insurance be encouraged to revise procedures to avoid expensive duplication of cost finding and audit mechanisms.

Currently there is a lag in the reimbursement to home health agencies of care rendered, as well as lack of assurance for agencies that the care provided will be reimbursed. We therefore recommend that:

Procedures be instituted to facilitate the flow of cash to agencies;

Procedures be developed for advance approval for home health benefits. However, we strongly urge that the advance approval standards be sufficiently flexible to permit coverage for patients who continue to need skilled nursing, physical therapy, or speech therapy services beyond the period initially approved; and

A provider appeals mechanism be established within the law. We also suggest that home health agencies be represented on advisory groups established to review, evaluate, or coordinate community health services.

You may remember that at the beginning of our testimony I told you of Mr. Doe. We have several other equally critical situations in which patients today would not have their services reimbursed under the medicare program. I do not want to take up this committee's valuable time recounting them.

We are most grateful to this committee for giving us an opportunity to present our views and to share with you our concerns for the patients in our care. Thank you, and we are certainly willing to answer any questions you may have.

Senator ANDERSON. Thank you very much for your appearance here today.

Reverend Eggers.

STATEMENT OF REV. WILLIAM T. EGGERS, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING; ACCOMPANIED BY FRANK G. ZELENKA, ASSOCIATE DIRECTOR; REV. CHARLES J. FAHEY, DIRECTOR OF CATHOLIC CHARITIES, DIOCESE OF SYRACUSE; BERTRAM B. MOSS, M.D., CLINICAL DIRECTOR, DIVISION OF GERONTOLOGY, CHICAGO MEDICAL SCHOOL

Reverend EGGERS. Mr. Chairman, I am Rev. William Eggers, administrator of the Home for Aged Lutherans, a 265-bed facility, participating in medicare and medicaid, in Wauwatosa, Wis.

I appear here today as president of the American Association of Homes for the Aging, an organization of nonprofit facilities for the aging, the greatest number of which are church related.

Accompanying me is Rev. Charles J. Fahey, a member of the AAHA board of directors, chairman of the AAHA interfaith group, director of Catholic charities, Diocese of Syracuse; Dr. Bertram B. Moss, clinical director, Division of Gerontology, Chicago Medical School. Also accompanying me is Frank G. Zelenka, associate director of the American Association of Homes for the Aging. Reverend Fahey, Dr. Moss, and Mr. Zelenka are here to help us respond to any questions that you might have. We have filed with the committee a

longer statement and are currently filing a brief summary and, with your permission, we will file some additional material in the future concerning our position on various points of H.R. 17550.

Senator ANDERSON. The staff will review that.

Reverend EGGERS. All right, thank you.

We have three points to make in an informal way before you this afternoon, and I would like to call on Dr. Bertram B. Moss, the clinical director of the Division of Gerontology of the Chicago Medical School as well as the medical administrator of the Parkview Home and the Jewish Home for the Aging. Dr. Moss, therefore, not only teaches but practices daily with older people. Dr. Moss.

Senator ANDERSON. Just bear in mind the time limit.

Reverend EGGERS. Yes.

Dr. MOSS. Mr. Chairman, from a medical viewpoint, we anticipate difficulty with the 90-day cutoff projected in H.R. 17550, section 225(a). We have to consider the multiplicity of illnesses that do exist in almost all elderly persons, and we also must consider the fact that there are many individual physical deficits in practically all older persons.

Each aged person has a specific ability to recuperate in reference to time, and this ability to recuperate is entirely unpredictable. It is unpredictable at the time of each illness and it gets more unpredictable as an individual has more and more illnesses and deficits within his body.

The entire situation of recuperation in the elderly is slow at its very best but it gets slower and slower as persons become more and more ill.

There are many complications that do occur when elderly people are recuperating from an illness or during their period of rehabilitation, and these happen often, and they are quite unpredictable.

What may be considered a minor complication for younger people as they recuperate from illness is often very grave among the elderly and this prolongs the time of their recuperation.

A specific limitation of time needed for the elderly to recover or to recuperate is impossible to prognosticate from a medical viewpoint and I think it would be impossible to state a definite number of days with a cut-off period.

Therefore, each elderly person should be allowed ample time to recover or to recuperate and not have an unnecessary length of time. By the same token, this can be accomplished with proper utilization review and medical audit mechanisms which already exist in law as well as those provided for in H.R. 17550. I believe that these should be continued.

The Social Security Act should continue to require in-house utilization review for purposes of in-house self-improvement in education as well as for consideration and recommendations concerning the needed benefits for the particular individual patient in question, and these cannot be determined specifically by law.

Thank you, Mr. Chairman, for allowing me to testify here today.

Reverend EGGERS. Dr. Moss was talking to 225(a), 90-day reduction of benefits in Federal participation which our association feels is inadvisable.

I would like to ask Rev. Charles Fahey, a member of the board of directors of the American Association of Homes for the Aging, chairman of our interfaith group, director of Catholic Charities of the

Diocese of Syracuse, and chairman of the Commission on Aging of the National Conference of Catholic Charities to discuss a second point briefly.

Reverend FAHEY. I would like to address myself to 225(b).

It is the position of all of those organizations which took so long to enunciate that this is a most unfortunate provision in the law based upon the false premise that the definition of intermediate care could mean a significant differential in regard to the cost of the provision of care.

There are many instances in which a person who would be located in an intermediate care facility so designated would actually require more services than a person in a skilled nursing home.

It is the position of our associations that the actual services rendered should be the basis of reimbursement rather than any presumptive services rendered. It would be most unfortunate if that which was unfactual became the basis for reimbursement and, as such became frozen into law.

We believe the concept of reasonable cost as is now prevalent in hospital care should be the kind of basis for reimbursement in terms of care whether in an intermediate care facility or in a skilled nursing home facility; that any other type of arrangement would be most unfortunate, and it becomes particularly unfortunate when it is frozen into law.

Reverend EGGERS. So our association, Mr. Chairman, feels that 225(b) with the provision that there must be by law a cost differential between skilled nursing care and intermediate care would be a very unfortunate thing to make law because——

Senator ANDERSON. Our staff will check that very carefully.

Reverend EGGERS. All right, thank you.

Our third point relates to a matter that is not a part ot H.R. 17550 but which we would strongly suggest to you that you consider making a part of the law, namely, that a task force be created under the aegis of this committee and of the Committee on Ways and Means; that the charge to this task force should be that it should examine the health care programs for the aging, not including the hospital programs, that are presently provided by the Social Security Act, with a view of trying to create a single program of care short of hospital acute care, and for which reimbursement would be provided on an individual patient basis according to reasonable costs. A second charge to that task force would be to try to see if it would not be possible and feasible and best for the interests of the aging and the country and the taxpayer to have facilities with a patient mix in them rather than to have the split that we now have between intermediate and skilled care and ECF and so on, which we feel has been done to a large extent, for reimbursement purposes.

We would propose that this task force be composed not of representatives of providers of care, nonprofit homes, or for-profit facilities, but of geriatricians, geriatric nurses, gerontologists, medical economists, and consumer representatives, provided that the consumer representatives do have experience in programs for the aging and have no personal financial interest in those programs.

We feel that the fragmentation of care, which has resulted from the many programs that now exist, is based on some assumptions that are erroneous.

I would like to read two sentences from our statement: "The erroneous assumption is that broad categories of care can be distinguished from each other with ease and precision, and this, in turn, has led to the equally erroneous assumption that there exists precise cost differentials between these broad categories of care, rather than as between individual instances of such care and the cost of caring for individuals in whatever physical or mental conditions they may have that require care." We feel that we have entered a period of great confusion, and the possibility of creating even additional programs which would split the care into even smaller fragments.

We suggest that the task force examine the possibility of creating something that we call, for want of a better name, a nursing care facility which would include all the levels of care and would have a proper patient mix. We think that this might prove more economical.

We would suggest that reimbursement be based on utilization review in connection with it, and on reasonable costs in connection with such a facility, and we would strongly urge that a new fresh look be taken at the whole problem that now faces our institutions.

With that, we conclude our informal testimony. We have been happy to appear here and would be happy to answer any question, should you have any.

(The statement follows:)

A Summary Statement of the American Association of Homes for the Aging

(Principal witness: Rev. William T. Eggers, president, AAHA; accompanied by Rev. Charles J. Fahey, director of Catholic Charities, Diocese of Syracuse; Bertram B. Moss, M.D., clinical director, division of gerontology, Chicago Medical School; Frank G. Zelenka, associate director, AAHA.)

OPENING REMARKS

Mr. Chairman and members of this important Committee, I am Reverend William T. Eggers, Administrator of the Home for Aged Lutherans, a 265 bed facility, participating in Medicare and Medicaid, in Wauwatosa, Wisconsin.

I appear here today as President of the American Association of Homes for the Aging, an organization of non-profit facilities for the aging, the greatest number of which are church related.

Accompanying me is Rev. Charles J. Fahey, a member of the AAHA Board of Directors, Chairman of the AAHA Inter-Faith Group, Director of Catholic Charities, Diocese of Syracuse; Dr. Bertram B. Moss, Clinical Director, Division of Gerontology, Chicago Medical School. Also accompanying me is Frank G. Zelenka, Associate Director of the American Association of Homes for the Aging. Rev. Fahey, Doctor Moss, and Mr. Zelenka are here to assist in answering any questions you might wish to put to us.

We are pleased to testify before this Committee today on H.R. 17550, the Social Security Amendments of 1970. Our direct interest is in Part B—Improvement in The Operating Effectiveness of Medicare and Medicaid. Part B embodies many proposals with which the Association agrees; some proposals concerning which we have reservations; and some proposals with which we profoundly disagree, namely, Section 225 (a) and (b). In addition, there are measures missing from Part B which we would urge this Committee to add to H.R. 17550.

Today, therefore, we would like to confine our remarks to those proposals with which we significantly disagree and, with your permission, submit a more detailed statement for the record.

SECTION 225

AAHA position.—Our responsibility as professional administrators of health care for the aged compels us to oppose the instrument which H.R. 17550 has chosen as the means to overcome the abuse of over-utilization, namely, the cut-

back in the Federal matching percentage after 90 days of skilled nursing home services. Hence, we urge that

Section 225(a) should be stricken from the bill altogether. However, our professional responsibility also compels us to admit the need for some advice by which the abuse may be policed. Hence, we urge that

(1) In an effort to overcome the abuse to which Section 225(a)(2) is addressed, Congress should enact Section 235 of H.R. 17550 which provides for utilization review under Title XIX;

(2) Congress should rely not only upon the utilization review thus provided-for but also upon Section 1902(a)(26) of the Social Security Act, the provisions of which became effective on 1 July 1969 but which most of the States have yet to implement. Congress should insist that he States immediately implement this provision for medical audit.

(3) Further, to insure that States will implement and carry out these provisions, Congress should provide that any failure on the part of a State to implement and carry out these provision will provoke a penalty on that State (rather than on the patient) in the form of a reduction in Federal maching monies to that State *in the subsequent year.*

COMMENTS

The Association rejects Section 225(a) for the following reasons:

(1) Such a provision implies two things both of which are false: (a) that a norm for length of stay ought to be based upon a stay in a specific kind of facility and (b) that 90 days in a calendar year constitutes a norm for length of stay in a skilled nursing home. The Association rejects (a) and therefore rejects (b). A norm for length of stay in a facility should be based upon one thing and only one thing, namely, the specific diagnosis of the patient's condition. We reject the notion that it should be based upon the definition of a specific kind of facility;

(2) The false assumption that there exists a norm for length of stay in a facility invites two grievous events: (a) rather than discourage over-utilization, it would tend to encourage such abuse, particularly where such abuse already exists, and (b) it would intrinsically risk under-utilization for those patients requiring more days of care than this false norm would allow;

(3) There is absolutely no rationale of any kind for applying or continuing Federal matching of any percentage where a medical judgement, sustained by utilization review and medical audit, has determined that the patient's condition never required or no longer requires a stay in a skilled nursing home; conversely,

(4) There is only a budgetary rationale for reducing the Federal matching percentage in any degree where a medical judgement, sustained by utilization review and medical audit, has determined that the patient's condition requires a length of stay in a skilled nursing home in excess of 90 days.

Therefore, the Association was driven not only to reject amending Section 225(a)(2) but also to oppose the original provision and does so categorically. Thus, it is that the Association recommends to this Committee that it strike the provisions of section 225(a)(2) altogether from H.R. 17550.

SECTION 225(b)(1)

AAHA position.—The Association urges the Senate not to adopt Section 225(b)(1) for the following reasons:

(1) The Association categorically disagrees with the premise upon which these provisions rest, namely, that the cost of care and services is determined only by the kinds of care and services—skilled or unskilled—which the facility is equipped to provide regardless of the amount of care and services—little or great—required by the patient's condition and *actually provided* by the facility to the patient; and

(2) Given this premise, Section 225(b)(1) concludes that intermediate care facility services *must cost less* than skilled nursing home services and that, therefore, there must exist within a State's intermediate care plan a reasonable cost differential between the two kinds of services.

The Association disagrees with the premise and therefore with the conclusion.

RECOMMENDATION

(1) The provisions of Section 1902(a)(13)(D) of the Social Security Act as amended by Section 220 of H.R. 17550 should apply to Title XIX skilled nursing homes and to Title XI intermediate care facilities; in addition,

(2) The Association would urge that the provisions for review contained in Section 1902(a)(26) of the Social Security Act and those provided for in Section 235 of H.R. 17550 also apply to intermediate care facilities under Title XI.

COMMENTS

It is the Association's position that the cost of care and services is determined by both the amount and the kinds of care and services required by the patient's condition and actually provided to the patient by the facility.

The test is evidently one of degree and this determination is best made by the physician and will vary from individual to individual. The quantities of care and services will, therefore, also vary from individual to individual. It is not difficult to conceive of an individual who would require quantities of care and services none of which were skilled nursing care, but all of which taken together in the aggregate would generate a sum of costs greater than that of skilled nursing care.

For example, a patient who would require admission to a skilled nursing home would be one who was suffering from a heart condition which had stabilized but who had an indwelling pacemaker. Such a patient would require the daily attention of a skilled professional nurse. His pulse would have to be taken daily and the nurse would be required to interpret the heartbeat, as to speed, strength and regularity. If the pulse is too slow, one kind of medication is required; if the pulse becomes too fast, still another kind of medication is required. During times of the slightest infection, the pulse can be affected. Hence, the need for a skilled professional nurse. Yet, this patient may have no other need for care and services. He is able to care for himself in all ways except that of the pulse taking and interpretation. Having no resources, this person cannot be a subject of home health services. The quantity of care and services is such that the costs thereof would be less than that of the following patient who could be cared for in an intermediate care facility.

This person is suffering from multiple sclerosis. He is becoming increasingly helpless and vegetative. This patient is incontinent. He needs to be assisted in and out-of bed; he needs to be spoonfed; he needs to have his position in bed changed every two hours else he would develop severe decubiti. The care and services required by this person in addition to room and board does not require a skilled professional nurse. Yet the accumulative cost of these units of care and services is such that their sum is *considerably greater* than that of the skilled nursing case previously cited.

THE DILEMMA POSED BY SECTION 225 (A) AND (B)

Let us pause now to consider Section 225 (a) and (b) together. We can see the fallacy and the threat therein. The patient with the indwelling pace-maker requires more than 90 days of skilled care. He would not be eligible for intermediate care because he has a condition requiring the care and services provided by a skilled nursing home. Although requiring skilled care, he is what is sometimes called "a light-care patient." If skilled care is reimbursed for on an across-the-board per diem, then his care is grossly over-priced. If skilled care must cost more than intermediate care, then this gross over-pricing would be fixed into place by law. . . . On the other hand, the patient with multiple sclerosis is eligible for intermediate care since he has a condition which requires care and services greater than room and board but less than skilled-nursing care. Although he does not require skilled care, he is what is sometimes called a "heavy-care patient." If intermediate care is reimbursed for on an across-the-board per diem, then his care is grossly underpriced. If intermediate care must cost less than skilled care, then this gross under-pricing would be fixed into place by law.

Our dilemma is forced upon us by the effort to fix both the length of stay and the cost of operation on the definition of a facility and upon the category of patient. The solution to the questions: what should the cost of inpatient skilled nursing home services be and what should the cost of intermediate care facility services be is the same as that which applies to hospitals, namely, the cost of services provided should be the reasonable costs of such services.

The Association, therefore, urges that skilled nursing homes under Title XIX and intermediate care facilities under Title XI be treated in the same manner as are hospitals under Title XIX and that the States should be required to pay the reasonable costs of care and services actually provided to the individual patient and that the States should be permitted to pay skilled nursing homes

and intermediate care facilities on the basis of the State's determination of the reasonable cost thereof, *provided there is assurance that the Medicaid and intermediate care programs would pay the actual cost of coverage of institutionalization of the recipients of these programs.*

RECOMMENDATION

The Association urges this Committee to add a new section to H.R. 17550 which would create a task force under the aegis of both this Committee and the Committee on Ways and Means. The charge to this task force should be that of examining the health care programs for the aged—excluding hospital programs—presently provided by the Social Security Act with a view to developing a single program of care for the aged which program would provide total comprehensive care short of hospital acute care and for which reimbursement would be based upon the actual reasonable costs of the care and services provided to the individual patient whether such reimbursement were retrospective or prospective.

A second charge to this task force should be that of defining a facility which would provide the care and services meeting the needs of this single program, looking not to a host of facilities each of which could provide only part of the care, but to a galaxy of facilities each of which would provide all of the care for a patient mix which would not only permit operational efficiency in the delivery of care but which would present to the taxpayer a true economy in the cost of care.

We are mindful that there have been task forces added to task forces. However, we suggest that this task force should be singularly different from those previously and presently in existence. We suggest that this task force exclude institutional providers of care and services—whether for-profit or not-for-profit—from its composition and that it be composed exclusively of geriatricians, geriatric nurses, gerontologists, medical economists, and consumer representatives, provided that these latter have experience in programs for the aged and that they have no financial interest—direct or indirect—with institutional providers of care and services to the aged.

COMMENTS

The very names of the health-care programs for the aged contained in the Social Security Act—Medicare, Medicaid, Intermediate Care—denote the central problem from which, in a certain sense, all the other problems emanate, namely, the problem of the fragmentation of care.

The fragmentation of care has resulted from the generation of progams which are based upon discrete definitions of facilities as the providers of care rather than their being based upon the needs and characteristics of the aged person as the subject of care. This has led to the erroneous assumption that broad categories of care can be distinguished from each other with ease and with precision. This in turn has led to the equally erroneous assumption that there exists precise cost differentials between these broad categories of care rather than as between the individual incidents of physical or mental condition requiring care within each of these broad categories of care.

The very definition of an extended care facility or of a skilled nursing home or of an intermediate care facility presumes the existence of an entire facility (or a distinct part of a facility) all of whose beds would be occupied by patients requiring extended care or skilled nursing home care or intermediate care as the case might be. The realities are that such a facility would be operationally non-viable.

What is needed is not kinds of facilities but a kind of facility, namely, a nursing care facility, an NCF, which is capable of providing care and services which together comprehend all the levels of care and services (short of hospital acute care) required by the aged.

Such a facility can receive and properly care for a patient mix. Such a facility could receive and properly care for patients requiring maximal care as well as those requiring minimal care, whether such care was required in some instances to be skilled and in others intermediate. Reimbursement for the care and services provided by such a facility should be based upon the reasonable cost of the routine care and services actually provided to the patient mix plus the reasonable cost of the ancillary care and services required by each patient's condition and actually provided to the patient by the facility.

The Association contends that such reimbursement coupled with the utilization of such comprehensive-care facilities would result in a more efficient utilization of personnel; in a lower overall program cost; and most importantly, serve to curb over-utilization while avoiding the inherent dangers in under-utilization.

It is for all of these reasons that the Association urges the Committee to bring this suggested task force into being.

RECOMMENDATION

The Association urges this Committee to add a section to H.R. 17550 which would amend Section 1121 (b) *to include* all those eligible for skilled nursing home benefits under Title XIX among those eligible for assistance in the form of institutional services in intermediate care facilities.

RECOMMENDATION

Amendment No. 851—Professional Standards Review

(1) The enactment of Amendment No. 851 as an integral part of the Social Security Act should be delayed and carried-over to the next Congress; however,

(2) Effective immediately, the provisions of the amendment should be authorized on a demonstration project basis in which there would be utilized several kinds of non-profit organizations as Professional Standards Review Organizations; the PSRO itself should be interdisciplinary in its composition; meanwhile,

(3) The utilization review and medical audit mechanisms which presently exist in law as well as those provided-for in H.R. 17550 should be continued during the period in which PSRO demonstration projects would be authorized; finally,

(4) In the event the amendment is adopted now or subsequently, the Social Security Act should continue to require in-house utilization review for purposes of in-house self-improvement and education.

Conclusion.—Thank you, Mr. Chairman, for allowing us to testify here today.

Senator ANDERSON. Thank you very much for a fine statement.

Reverend FAHEY. If I may indulge, Mr. Chairman, for one moment and request, first of all, that an additional statement may be filed with you on behalf of the National Conference of Catholic Charities which has been prepared and given to the clerk and submit it for the record.

I don't know whether it would be in order to perhaps spend 1 minute to highlight one feature of it that goes beyond the testimony of the American Association of Homes for the Aging but does pertain to the national conference; would that be in order at this time?

Senator ANDERSON. Go ahead, 1 minute.

Reverend FAHEY. Yes. It is in reference to amendment 851 and we feel it is especially appropriate in the presence of the Honorable Senator from Utah who introduced it. We see this proposal as one of great interest in having many very favorable aspects to it and I will speak for the National Conference of Catholic Charities. It is obvious it would be advantageous to have peer review. It would be helpful to facilities. However, our basic constituency are not facilities or doctors, although we have many facilities and physicians, but people, particularly, the disadvantaged person. We are concerned that the PSRO would be another block in the way of the poor in obtaining care and services. We have a genuine concern in regard to the sheer weight that would be involved in this program. We have much experience with utilization and review committees and fiscal intermediaries in terms of their ability to deal with our agencies and facilities at the present moment. This causes many problems for agencies and facilities.

It would seem as if the mechanism which is proposed would move this into the realm of the relationship of doctor and patient, particularly the disadvantaged patient, and so while being unable to speak,

I am neither old nor a minority group person nor particularly poor, I think these consumers have a major stake in this particular provision. Therefore, it is with some concern that we view it. We wish that it would be considered very carefully not only by physicians and providers of service but that also consumers would have an opportunity to see whether or not this provision that hopefully would increase quality and the economics of the provision of care, would actually accomplish this worthwhile end. We wonder if it is going to be one more obstacle in the ability of the poor, the elderly, and minority groups to be able to participate in our health care system in this country.

So we are not in opposition to it, but raise a major question and feel that it deserves a considerable amount of debate on the local scene, a debate that up until this point I think has been lacking and probably will be lacking before the Senate has an opportunity to consider it fully.

Senator ANDERSON. In view of the Bennett amendment, if you have a special view why don't you write it and present it to us?

Senator BENNETT. Mr. Chairman, just for the record I would like to make the point that peer review, as we contemplate it, goes to three basic questions: whether the treatment is medically necessary, whether it has been given in such a way as to be up to professional standards, and whether it is medically appropriate.

I don't think consumers can contribute very much to those three professional problems.

Reverend FAHEY. Except, of course, if this mechanism is going to make it more difficult for the consumer to receive the service. This is the key element.

Senator BENNETT. I don't see why it should.

Reverend FAHEY. Well, we have tried to estimate, just in our own mind and in our own community, it would seem as though this might, for example, in a county of some 500,000 persons, could involve almost a hundred reviews per day. The ability of our local medical society to provide adequate utilization review for a relatively few number of extended care facilities at the present time is very difficult. The ability of Blue Cross and Blue Shield and its mechanisms to be able to provide an assessment of cases in regard to extended care facilities has proved to be a rather difficult thing. These are all post factum kind of considerations of the persons who have received the benefit of service in ECF's and medical service.

Now, the question is, if it comes that this kind of a mechanism is going to have to be utilized ante factum before service is received. Granted it is elective procedures in medical service, the question is how long a delay, how many doctors are going to want to participate in it and whether or not it is going to interfere with individuals being able to receive costly extended therapy programs on an outpatient basis or inpatient. This is a question mark in my mind.

Senator BENNETT. I think you are misunderstanding the approach. The approach is that if there is adequate time, without interfering with the health of the patient for previous review, that can be given. But if it is necessary to start a treatment immediately this will be reviewed afterward. Under no circumstances is it intended that patients be held out of hospitals or be denied needed medical service on the ground that "we can't do it until we have a chance to review your

case." The proposal in its entirety assumes that actual time-consuming review will only be used for those cases that seem out of pattern or unusual.

If the case is usual in terms of suggested treatment, it can go on through without any question, but if a physician undertakes to suggest that because a child has a tonsillectomy maybe it is going to be necessary to take out its appendix and a few other things, we will have to look at that.

Reverend FAHEY. Certainly this is a very reasonable approach. Our only concern is that at the present time many physicians seem to be reluctant to participate in, for example, medicaid programs, because of the redtape and so on in terms of reimbursement. We wonder about their willingness to participate in such a program that will involve even more kinds of activities on their part in terms of submitting material, in terms of even ordinary procedures.

Senator BENNETT. OK. If they choose not to participate, then there are others, the Secretary of HEW has the power to develop other units to do the reviewing. We are not dependent entirely on the participation of the physician.

Reverend FAHEY. Yes. I think the point I would like to try to make is it would not only be the review mechanism and the willingness of physicians to participate in that, but the willingness of individual practitioners to utilize this mechanism, to submit to this kind of thing. I think this is a concern of whether or not John Jones who is now serving half of his clients in medicaid or whether he is going to want to go through all of this or is going to hang up a sign saying, "No medicaid patient need apply."

Senator BENNETT. I think he would be much more willing to be reviewed by his peers than a bureaucrat from Washington or a clerk in some office. And so I think that this is a bugaboo that will disappear.

My own feeling is that the reluctance of physicians is based more on the fear that their fees may be cut down than that the mechanism will interfere with their actual service relations with their patients.

Mr. ZELENKA. You indicated earlier it would not be an obstacle to admission, medical service, this ante factum aspect.

Senator BENNETT. That's right.

Mr. ZELENKA. Suppose there is a delay and the attending physician is concerned and he does move for admission, then review takes place and they decide that admission shouldn't have taken place. What will then happen, given the first premise in the proposed amendment that all payment will be based on what the PSRO determines?

Senator BENNETT. If the delay has been caused by the PSRO, then there will be no denial of reimbursement, even if the review later discovers that it was improper. In other words, we are not going to allow the PSRO by bureaucratic failure or by delays which are unreasonable or improper, we are not going to permit that to deny the patient the financial protection.

Mr. ZELENKA. I would like to also say, and take this chance to say, we do commend you for this proposal. We think it is momentous. Our problem, I think, is that we are mesmerized by it.

Senator BENNETT. We have had some experience with medicare and medicaid, and we in this committee know if something isn't done within a few years the thing will break the back of the medical pro-

fession, the hospital services, and the U.S. Treasury. We are trying to suggest a mechanism which can control this most effectively. Since the objective is the health care of the patient, and since the physician, quoting another witness the other day, is responsible for 80 percent of the decisions which involve the health care of the patient and the cost of the service, we think he is the logical person in terms of a peer review mechanism.

So far as nurses and nursing homes and chiropractors and others are concerned, the system provides that the PSRO group can call in these people to advise them. There is built into the mechanism an official advisory group containing these people, to which the physician can turn. So the peer review groups are not in position completely to ignore the other aspects of the total health care picture.

Mr. ZELENKA. Mr. Chairman, if the chairman will indulge one more question, we are a little concerned about some of the language.

I indicated to the staff earlier that it might open the door to the PSRO being a profitmaking company or corporation or whatever, the language "or such other organization as the Secretary may deem otherwise suitable."

Senator BENNETT. I have two reactions to that. Hopefully, the members of the review group, will be rotated. It is not going to be a little elite group that get in a position where they can control things from now on out, and if the physicians either are unable or unwilling to provide this kind of review, then we have to turn to someone else. It is assumed that the Secretary will do everything he can to avoid getting involved with any group that has a profitmaking capability.

Now, there are costs, and they are going to have to be met, but we are going to do the best we can to see that in meeting those costs we do not create a profitmaking operation.

(Statement of the National Conference of Catholic Charities follows:)

STATEMENT OF THE NATIONAL CONFERENCE OF CATHOLIC CHARITIES, PRESENTED BY REV. CHARLES J. FAHEY, CHAIRMAN, COMMISSION ON AGING, NCCC

In the amendments to the Social Security Act contained in H.R. 17550, there are extensive and representative matters of great interest to the National Conference of Catholic Charities. Our concerns embrace the millions of elderly and retired persons in the United States, and our activities relate to the services provided by nearly 500 homes for the aged in this country. Our comments in this statement refer to items in H.R. 17550 which touch the matter of the basic assistance of Social Security beneficiaries and also items which have particular meaning for many of our institutions for the care of the aged.

In reference to these latter items, we are collaborating in testimony with the American Association of Homes for the Aged and the Department of Health Affairs of the United States Catholic Conference, and endorse the recommendation which these organizations present, especially with reference to Section 225 (a) and (b) of H.R. 17550. These refer to the reduction of Federal contributions to payments for persons who continue in a skilled nursing home beyond 90 days, and also the type of differential care which must exist between a skilled nursing home and intermediate care facilities. We have serious concern about both of these provisions as embodied in the proposed legislation. We also have many questions about the intent and effect of the amendment proposed by the distinguished Senator from Utah, Mr. Wallace F. Bennett. Our position on these matters will be presented in joint testimony with the American Association of Homes for the Aged and the Department of Health Affairs of the United States Catholic Conference.

BENEFIT INCREASE

Certainly an increase in Social Security benefits is warranted and necessary at this time. It is true that it has been only a year since the last increase, a substantial one, was voted by Congress. But this year has seen a strong increase in inflationary pressures which have included a significant portion of the benefit increase. The five percent increment included in H.R. 17550 is barely sufficient to underwrite the increase in the cost of living during the past year. It should be enacted.

We are still concerned, however, about Social Security beneficiaries who receive only the minimum amounts. The minimum benefit accruing to a worker retiring at age 65 at the present time is $64.00, which represents a gradual increase over the past decade. In H.R. 17550, it is proposed to advance this to $67.20. We believe that a greater increase should be proposed for these persons, for whom Social Security benefits are frequently their only source of income, which must be supplemented by public assistance payments which are inadequate.

Similar consideration dictates the liberalization of the employment test for recipients of Old Age, Survivors and Disability Insurance. For so many persons, their income from these benefits is inadequate to enable them to live in decency. They must seek other income. One type, a very important type, is employment income. The amount of such income which a recipient may earn before retirement benefits are reduced, should be increased. Certainly, the figure of $2000 is more realistic than the present $1680.00. It represents an increase commensurate with the increase in the cost of living.

Such an increase in the amount of earnings for a Social Security recipient is important for other reasons besides those related to the economical situation of the recipient. It is also related to the psychological and physical need of the person to continue to be occupied in meaningful employment. Many older persons, even if retired from their usual job, still must find activity and fulfillment in structural and remunerative service. They are somewhat deterred from this by the income reduction represented by the Social Security employment test. This negative impact should be mitigated as much as possible. This can be partially accomplished by raising the present basic earnings amount to $2000.00.

AUTOMATIC ADJUSTMENT OF BENEFITS

One of the most important provisions of H.R. 17550 is the inauguration of a system of automatic adjustments of Social Security benefits related to and determined by the increase in the cost of living in any year. It is obvious that the cost of living continues to rise, and, in effect diminishes the value of the fixed income of Social Security beneficiaries. As a result, Congress regularly must consider this phenomenon and enact separate legislation to rectify its influence on these beneficiaries. It is only reasonable and just that a standard mechanism be built into the Social Security system to acknowledge this yearly inflationary increase in living costs and to adjust benefits accordingly. The Committee is to be commended for including this among the proposed amendments to the Social Security Act, and we sincerely hope that this particular amendment soon becomes law.

RELATIONSHIP TO PUBLIC ASSISTANCE

The financial needs of Social Security beneficiaries which are not met by Social Security payments must be met in many instances by public welfare payments, usually by Old Age Assistance. This prompts us to voice once again, our support for the improvement in public assistance benefits and for reform of the public welfare system. These issues are before this esteemed Finance Committee of the U.S. Senate in the form of H.R. 16311. In this bill, the minimum Old Age Assistance grant is increased to $110.00 per month, and the earnings disregard is liberalized. These are very desirable amendments.

Equally desirable, or even more so, are the provisions in H.R. 16311 for reform of the welfare system. The foremost need in the field of social welfare today is the reform of the public welfare system. This need is recognized by most everyone, and has been given expression in a variety of ways—from the studied phraseology of the student of welfare, to the complaints of welfare workers, to the demonstrations of welfare recipients.

The legislations before this committee must be analyzed first of all in its provisions for welfare reform. While other aspects of the Family Assistance Act

are important, the most important question is how well this central problem is solved.

Upon analysis, it must be said that H.R. 16311 makes a good beginning toward reform of the welfare system. What prompts this conclusion is the burden of one of the early sections of our lengthy statement.

However, whatever the merits of H.R. 16311 toward welfare reform, the accomplishments of the needed reform of the welfare system is the task now before this Committee. We urge you to accept or develop the legislative proposals needed to bring about meaningful welfare reform *now*. Whatever you do to other portions of the bill, we strongly request that you report out a measure which contains significant reform of the welfare system.

We appreciate the opportunity to present this statement. We especially appreciate the efforts of the Senate Finance Committee to improve the lot of Social Security beneficiaries, and to enact significant reforms in our public welfare system. The National Conference of Catholic Charities assures you of our whole-hearted support and assistance in these noble efforts.

Senator ANDERSON. Our last witness is Bernard Tresnowski, vice president for Government operations, Blue Cross Association.

STATEMENT OF BERNARD R. TRESNOWSKI, SENIOR VICE PRESIDENT FOR GOVERNMENT OPERATIONS, BLUE CROSS ASSOCIATION

Mr. TRESNOWSKI. Mr. Chairman, the hour is late, and the committee has been here for a long time this morning and I would recommend that the statement of the Blue Cross Association be inserted in the record as officially read, if that is acceptable to you, and, therefore, I would not read the statement.

At this time, I would like to call your special attention to the provisions concerning health maintenance organizations. I would also like to underscore the comments that we make concerning the amendment offered by Senator Bennett, and simply state that we have some grave concerns about removing the beneficiaries under the various titles of the Social Security Act from the peer review activities that presently exist in institutional providers of existing agencies and turning these review activities over to another organization. It would seriously diminish their effectiveness to the beneficiaries and subscribers now covered under the various titles of the Social Security Act.

We also feel that the utilization of physician services and the resulting costs are not simply professional judgments. The sum total of these decisions become questions of public policy and the need is for affirmative and accountable public and managerial action rather than a narrowing of the decisionmaking to professional societies.

With regard to this amendment, we urge that it be modified so that the function of professional standards review organizations be directed at the establishment of standards and norms to be used by institutional providers in their review activities as well as by financing agencies in their claim review activities. The professional standards review organization should also be available on an appropriate agreement basis to substitute for the gaps existing in review in such areas as home and office care, ECF, and home health.

Thank you, Mr. Chairman, for this opportunity to present this statement on the views of the Blue Cross Association.

(The prepared statement follows. Hearing continues on p. 780.)

STATEMENT OF THE BLUE CROSS ASSOCIATION, PRESENTED BY BERNARD R. TRESNOWSKI, SENIOR VICE PRESIDENT

Mr. Chairman, my name is Bernard R. Tresnowski, I am a Senior Vice President of the Blue Cross Association, the national organization of Blue Cross Plans and I appear here today as a representative of those Plans to offer our comments on H.R. 17550—the 1970 amendments to the Social Security Act.

Since Medicare went into effect July 1, 1966, the Blue Cross System has processed about 50 million Medicare claims and handled payment of $16.3 Billion in benefits for the nation's elderly. Last year Blue Cross paid out $4.2 Billion in Medicare benefits.

Blue Cross now serves the vast majority of the nation's 20 million elderly citizens covered under Part A of Medicare. As Fiscal Intermediary, Blue Cross serves 91% of the country's hospitals, 88% of the home health agencies and 52% of the extended care facilities.

Figures on administrative costs for processing Medicare claims show that from July through September, 1969, the Blue Cross System administered 3.5 million Medicare bills at a cost of $3.67 per bill—or 1.22% of total benefit payments for the period.

Comparable administrative cost figures for three other Intermediaries show that the next largest Intermediary—in amount of business handled—processed only 97,598 bills at $5.73 a bill—for an administrative cost of 1.59%. The third Intermediary administered 76,647 bills at $5.13 a bill for an administrative expense of 1.31%; and the fourth Intermdiary handled 69,428 bills at a cost of $5.32 a bill, or 2.05%. We are proud of our record.

In its work to make Medicare run smoothly during the past four years, the Blue Cross System has developed a magnetic "Tape-to-Tape" computer program to speed claims processing and to eliminate clerical errors at the Social Security Administration's Medicare Records Center in Baltimore. The Michigan Blue Cross Plan developed the prototype program through which hundreds of paid claims are put on magnetic tape and airmailed daily to the SSA's Baltimore Center. The tapes, when fed into SSA's computers, automatically update and close patient records in the Medicare Master Record files. The System dramatically cut the number of days required to process claims—from 18 days to 2. And, with the savings in clerical time, SSA was able to improve time lags in other processing areas. We estimate that savings through the "Tape-to-Tape" system will be more than $1,250,000 in the current fiscal year. The system's value continues to increase as the volume of Medicare claims grows. Presently, 40% of Medicare claims are processed under this program. By the end of 1970 we expect over 50% of claims on Tape-to-Tape with concomitant additional savings to the program. Volume has more than doubled during the past four years, going from more than six million bills processed in 1967, to nearly 15 million a year at present.

In addition to Tape-to-Tape, other Blue Cross efforts to meet the increased claims volume and ease administration of Medicare include the development of a simplified, in-depth method of auditing the records of hospitals and nursing homes; a new set of guidelines for determining the level of nursing home services covered by Medicare; and the present implementation of an automated model computer program for processing all hospital, nursing home and home health care claims.

Since Medicare's beginning, use of the System's telecommunications system for both regular Blue Cross and Medicare business has risen 500%. In 1970, Blue Cross is scheduled to increase its communications capabilities by another 250%, which will enable it to transmit 100 million characters (nine million words) per day. Under the old system, the volume was about 40 million characters per day.

In each year of Medicare, the Blue Cross System's performance as Intermediary has shown steady and impressive improvement, and has proved that a public-private partnership can preserve the important element of public accountability in a government program, while capitalizing on the assets of existing private institutions.

As the largest Intermediary under the Medicare program and as a participant in the administration of the Title XIX program in 22 states, we have assisted the Congress through the development and amendments to the legislation affecting these programs. In our various appearances before the Congress we have sought to relate our knowledge of program administration to the various

provisions offered in the light of their impact on the simplification of the program, meaningful controls over costs and use and the development of an atmosphere of innovation and experimentation. Progress has been made in the areas of simplification, predictability and experimentation in the Medicare and Medicaid programs since their enactment in 1965. The first years of the program were directed at eliminating unnecessary administrative burdens and simplifying the system. The second, third and fourth years of the programs have surfaced the need for predictability of costs and use under the program and the apparent need for meaningful controls. In the last few years it has become abundantly clear that experimentation is necessary if our variegated health care system is to provide care with reasonable effectiveness and efficiency.

In examining the various provisions of H.R. 17750, it is our opinion that many of them contribute to the aforementioned themes while others do not. Some provisions potentially can improve the program but they appear to be excessively complicated or administratively structured to defeat their original intent.

Because a major thrust of the Medicare and Medicaid provisions of H.R. 17550 is to improve the effectiveness of these programs, I would like to comment on the proposed modifications within that context. For ease of reference paragraph identifications which follow are those used in the Bill.

Section 201.—Payment Under the Medicare Program to Individuals Covered by a Federal Employees Health Benefits Program

Prior to the effective date of the Medicare program, Blue Cross developed and made available complementary insurance programs to Parts A and B of the Medicare program. Presently we cover approximately 6 million of the over-65 population on a complementary basis. The provision in the Bill would require an amendment to the Federal Employee Health Benefit Act to authorize the Civil Service Commission to provide a supplementary insurance program for the over-65 Federal employee. Because this provision is intended to assure equity in coverage for the over-65 Federal employee, we support it and are prepared, as the nation-wide service benefit plan, to assist the Civil Service Commission to administer an appropriate amendment to the Federal Employee Health Benefit Act drawing upon our experiences with the aged.

Section 221.—Limitation on Federal Participation for Capital Expenditures

This section is especially noteworthy in that it represents an endorsement of the principal that third-party financing of capital expenditures should be linked with participation in planning. The Blue Cross Association and its Member Plans have long supported areawide planning and continue to do so. We believe that the local planning agency must have the right to advise public and private financing agencies concerning the use of funds. Third-party agencies should have relationships and linkages to obtain the advice of planning agencies and internal mechanisms to consider such advice, although they should not be bound by the decisions of planning agencies. We believe that the provisions of this section will stimulate greater use of existing mechanisms by encouraging fiscal agencies, private as well as public, to seek advice and recommendations from local and state planning groups.

We recommend that the definition of capital expenditures cover not only depreciation, interest, and return on equity capital, but be expanded to include the replacement or major renovation of buildings and addition of plan equipment for new services.

When under this section the Secretary decides to withhold reimbursement, there should be a provision to allow a provider formally to request an appeal and a reconsideration of the Secretary's decision.

A note of caution is necessary. The development of planning agencies around the country has been uneven. Some agencies may not be prepared to cope with this responsibility. Cautious administration will be necessary and the Secretary must have discretionary authority in designating and contracting with planning agencies.

Section 222.—Report on Plan for Prospective Reimbursement; Experiments and Demonstration Projects to Develop Incentives for Economy in the Provision of Health Services

The 1967 amendments to the Social Security Act, under Section 402, grants authority for the Secretary of HEW to engage in experiments to develop incentives for economy in the provision of health services. Some experiments have been

undertaken during the past two years. These experiments hold promise for future returns in controlling costs. However, at the present time the experiments are still in progress and they cannot yet be evaluated. H.R. 17550 would enlarge the scope of such experiments to include in addition to reimbursement systems, payments for services for residents, interns and supervising physicians and utilization review. We support this extension. It further places an additional administrative control point in the Senate Finance and House Ways and Means Committees. It is our understanding that such a control point has been included in this provision to assure that experiments are not developed which would lead to systems which would be inimical to the intent of Congress in the enactment of the Title XVIII and XIX programs. While control is important, it would, in our opinion, if exercised in this way, detract significantly from the administrative responsibility of the Secretary and, conceivably, hamper his leadership role in implementing legislative policies and programs.

Section 223.—Limitations on Coverage of Cost Under the Medicare Program

Blue Cross serving both as an Intermediary under Medicare and in our role in other Government programs, as well as in the private market, is vitally concerned about the matter of reasonable provider costs. During the past four years there have been many actions taken to assure reasonable purchase of care on behalf of the Medicare beneficiaries by Blue Cross. There have been a significant volume of appeals by providers from cost allowability determinations made by Blue Cross and we have sought carefully to identify situations where costs are incurred under circumstances intended to seek a financial advantage and taken action to disallow these costs. In our private programs we have worked under various approaches to cost containment within the framework of total cost control, such as limitations on the lower of cost or charges; ceilings on cost increases between accounting periods and negotiated target rates on total or departmental costs, among others.

The most pertinent regulation applicable to Medicare and Medicaid governing cost limitations is Section 405.451(2) which reads:

"The cost of provider services may vary from one provider to another and the variations generally reflect differences in the scope of services and intensity of care. The provision in Title XVIII of the Act for payment of reasonable cost of services is intended to meet the actual costs however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area, which are similar in size, scope of services, utilization and other relevant factors."

Our interpretation of this regulation and our administration of it to date has been in terms of disallowance on the basis of total costs. With utilization review and accreditation safeguarding quality, focus on total cost, while alert to groundless aberrations in specific elements of cost, recognizes that there is more than one management road to efficiency, is less manipulative of management and assumes a less expensive administrative cost burden. The use of overall cost ceilings rather than individual elements of cost, coupled with the Bill's provision for prospective application would allow for the establishment of understandable criteria for total cost limits; provide an opportunity for the provider to appeal their classification and would also facilitate the Bill's provision for permitting the provider to charge a beneficiary costs in excess of the Medicare ceilings. The application of the overall ceiling would permit variation in the components of cost and would apply an effective control on extra-ordinary high costs as a result of low occupancy rates or other factors related to the inefficiency in the production of services.

Accordingly, we recommend that the committee's provision on prospective application of cost ceilings be retained and that such cost ceilings be limited to overall costs by class of hospital with an opportunity for the provider to appeal such classification.

Section 225.—Establishment of Incentives for States to Emphasize Outpatient Care Under Medicaid Programs

We support the purpose of this provision which is to enlarge the scope of benefits and provide alternatives to expensive inpatient care, but we are convinced that arbitrary limitations on the duration of care in institutions is inappropriate and will not reach this goal. Artificially imposed constraints inhibit the implementation of modern concepts of care and will put the burden on people who cannot afford it.

A flexible approach to patient care should be based on patient's need, therefore we oppose the limitations in this section.

Section 226.—Payment for Services of Teaching Physicians Under the Medicare Program

We note that this provision identifies that Medicare beneficiaries may elect voluntarily to become recipients of care in teaching institutions under an assigned physician's responsibility. We concur in this provision of the Bill which applies principles established under combined billings for hospital-based physicians by eliminating deductible and co-payment amounts with payment on a cost basis.

Section 227.—Authority of the Secretary to Terminate Payment to Suppliers of Services

It is not clear in this provision whether the authority to terminate granted to the Secretary relates to providers of care. Providers of care presently have an agreement with the Secretary which identifies terms under which the agreement can be terminated. To include providers of care under this provision would appear to conflict with the standards established for provider certification, the guidelines for covered care as they serve to define benefits under the programs and existing institutional utilization review procedures. These controls over quality and use plus the existing agreement with providers of care make their inclusion in this provision unnecessary. Accordingly, we recommend that providers of care as defined in the law be excluded from this provision recognizing that other sections of the law and regulations provide controls and speak to termination of payment to them.

Section 229.—Determination of Reasonable Cost of Inpatient Hospital Services Under Medicaid Maternal and Child Health Programs

The definitions of reasonable or allowable costs have been debated and essential agreement achieved. This agreement is reflected in the principles of reimbursement under the Medicare program. Further, the reporting of costs to be applied to these principles has been established under the Medicare program and is being coordinated with Medicaid and the Maternal and Child Health programs. We agree that it is desirable to offer the states flexibility based on the characteristics of their population to establish a varying method of payment, such as RCC, per diem, or such other option which may be equitable to the program and the providers of care. However, variability in method of payment should be related to a common set of definitions concerning allowable costs as developed under Title XVIII with the concomitant opportunity for uniform cost reporting and audit systems.

Section 230.—Amount of Payments Where Customary Charges for Services Furnished are Less Than Reasonable Cost

This provision relates directly to the cost containment provisions under Section 223 of this Bill and would serve as a motivation to relate charges to cost. We have followed this practice many years in Blue Cross and found it productive. We support it. The opportunity to carry-over the difference between cost and charges to a subsequent period provides adequate relief to allow for low occupancy either for new providers or those undergoing building programs.

We recommend that this provision authorize the Secretary to develop, through regulation, reimbursement systems for providers who make nominal charges or have no charge schedules. The reimbursement system should include per diem cost or percentage thereof; an option made available earlier in the program for all inclusive rate hospitals.

Section 231.—Institutional Planning Under the Medicare Program

It is essential that providers of care vigorously engage in the process of planning by establishing objectives identifying their operating assumptions and appropriately allocating their resources in accord with these planning objectives. We endorse a provision in the Bill which would further motivate providers to engage in this type of planning process.

We note, however, that the development of operating and capital budgets would not necessarily serve this planning function and be viewed as an unwarranted intrusion in management.

We recommend that this provision be amended so that operating and capital expenditure budgets be redesignated as *program plans* which identify the objec-

tives, the services to be provided and a plan of anticipated income and expenses in support of the institutional plan for a three year period.

Section 232.—Payments to States Under Medicaid Programs for Installation and Operation of Claim Processing, Information Retrieval Systems

The major administrative and planning problem under the Title XIX program has been the lack of program information or the establishment of easily accessible eligibility files and effective utilization review systems. We endorse this provision which will provide additional Federal financing for the development and maintenance of such information retrieval systems where none exist.

We would strongly urge, however, that the Congress give recognition to the existing capability for such systems by those organizations contracting with the state agencies under the Title XIX program. The Task Force on Medicaid and Related Programs specifically recommended that:

"The operation of health-service activities should be decentralized through contractual agreements with public and private agencies. The principal features of such agreements should be specification of desired outcomes, rather than specific methods of operation and evaluation and information systems that can assess performance in terms of output or results."

In commenting on this recommendation the Task Force noted that the setting of standards and policy and the evaluation processes were especially appropriate functions of Government.

To assure that the opportunity is available we recommend that the authority of the Secretary under this provision be extended to include the financing of management information systems developed by either public or private organizations with demonstrated capability to establish and maintain such systems under contract with the state agencies.

Section 233.—Advance Approval of Extended Care and Home Health Coverage Under the Medicare Program

One of the most serious administrative problems affecting the beneficiary under the Medicare program has been the retroactive denial of benefits for care in extended care facilities and home health agencies. The committee's provision would authorize the Secretary to establish criteria by medical condition for approved periods of stay in extended care facilities and home health agencies. We note that this provision gives authority to the attending physician to certify a plan for furnishing the care in accord with the criteria established and authorizes the utilization review committee to examine the stay during the duration of the approved period.

It is further provided that abuses by certifying physicians under this provision would be monitored by Intermediaries and that physicians who were found to be unreliable would lose the privilege of certifying patient needs in subsequent periods.

We recommend that the provision be amended to assure that physicians whose reliability in certifying patients needs is questionable the opportunity of notice and hearing. Such procedure to be structured as a fair hearing with opportunity to present evidence concerning their use of the advance approval procedure prior to suspension from the procedure on any subsequent patients.

Section 237.—Notification of Unnecessary Admission to a Hospital or Extended Care Facility Under the Medicare Program

Retroactive denial of ECF and HHA benefits arises from established criteria of covered care by these providers. The criteria for reasonable and necessary care in hospitals have not been clearly established by the program or the Intermediary. Such criteria represents a statement of medical practice standards. This authority has been granted to the utilization review committee in their sample review of the medical necessity of admissions.

This provision of the Bill offers an opportunity for the utilization review committee to terminate payment after a three-day notice period on admission found not to be medically necessary. This additional authority granted to the utilization review committee further underscores the importance of establishing criteria for medical necessity which will be applied by the utilization review committee in this new responsibility as well as to the Intermediary in its claim review responsibility. It should be understood that the Secretary would have to direct that the Intermediary solicit from the utilization review committee such criteria as used in the determination of unnecessary admissions so that these same criteria could be developed for use in claim review for reasonable and necessary care in the hospitals and extended care facilities.

Section 239.—Payment to Health Maintenance Organizations

Blue Cross Association views this measure as a positive step in providing for a choice of health delivery systems and encouraging movement in the direction of predictability of costs, access to care and responsibility for defined populations. In addition, it appears to move in the direction of providing economic incentives for effective and efficient delivery of health care serivces without detailed prescription of the administration of that delivery system.

This section would offer program beneficiaries the opportunity to select a health maintenance organization for the delivery of benefits under both Parts A and B with the program paying for such benefits on a capitation basis not to exceed 95% of the costs of Medicare benefits in the beneficiary's geographic area.

It would be desirable to have more specific information on how the 95% figure will be calculated. It could vary considerably depending on whether the "area" is a city, region, or, state. The committee should recognize that high start-up costs may prevent developing HMO's from functioning within the 95% level. We would recommend authorizing 100% levels of payment of costs for the first years of new HMO's when this is necessary.

Further, we suggest that incentives are needed for both providers and consumers to join HMO's and, thus, HMO's should be allowed the full 95% and be permitted to reduce the charge for the coinsurance and deductible to the extent of the extra premium. They should be encouraged to offer as broad a range of benefits as they can, beyond the minimum of Parts A and B without additional premiums. Also, HMO's should be allowed to offer extra services for additional premiums, but not require subscribers to purchase these options.

We recommend that appropriate standards for participation of health maintenance organizations in the Medicare program be established to assure that the traditional functions of risk-taking and health benefit delivery with patient care and health services delivery will be appropriately meshed. Standards are required in the areas of financial integrity, adequate underwriting resources, identification of the population to be served, benefit scope and arrangements with provider elements associated with the health maintenance organizations.

We also recommend that there be annual open enrollment and continuous enrollment of new eligible beneficiaries for HMO's. Beneficiaries should be eligible to drop out only during open enrollment periods.

We recommend that statute and regulation should be flexible on how HMO's in such places as ghettos are to achieve a balanced population and make provision for flexibility in such circumstances.

The committee should be cognizant of the fact that existing state laws against group practice may significantly slow the development of HMO's. Steps should be taken by the Federal government to see that anachronistic legal regulations are changed and modernized using participation in Hill-Burton and other Federal programs as incentives if necessary.

Finally, under a per capita payment, the incentives for controls on cost and use are reversed from our traditional fee for service system. This is one of the objectives of such a system; however, it will be necessary to develop performance standards to assure consumer protection and monitoring of the quality of care rendered under a Health Maintenance Organization. Profits must be kept at a reasonable level and not gained from beneficiaries by limiting access to needed services.

Section 254.—Physical Therapy Services Under Medicare Program

This section covers physical therapy services furnished by an independent practicing physical therapist, in his office, or in the patient's home, under regulations prescribed by the Secretary. Also, it provides for reimbursement for the reasonable charges for the covered services to be made either to the beneficiary or, on assignment, directly to the physical therapist.

We oppose this new section and support the law as it is currently written. Not only will this increase the administrative burden, but it will increase fragmentation of the health care system by supporting and encouraging the independent practice of physical therapy.

We believe these sections will create precedents detrimental to good patient care. They will obviate the necessary management of patient care programs by medical practitioners including control over the quality and continuity of care.

Amendment 851.—Professional Standards Review

The stated objective of this amendment is to "promote the effective, efficient, and economical delivery of health care services, for which payment may be

made . . . under the various titles of the Social Security Act". Specifically, this amendment provides for the designation of professional standards review organizations with such organizations qualified in order of preference, as

(a) a non-profit professional society

(b) such other public non-profit, private or other agency or organization which the Secretary determines has the professional competence and is otherwise suitable.

The objectives of this proposed amendment and the creation of professional standards review organizations as the primary mechanism of control fails to take into account the importance of the interdependence of existing organizations and their peer review activities operating in the health care delivery system today.

The notable example is the institutional provider of care. In the hospital setting there are defined functions of professional and clinical review by the medical staff all serving the objectives of effective and efficient delivery of health services. These include provision for:

Executive Committee—whose functions among others include coordination of activities and general policies of the various departments. Implementation of approval policies of the medical staff.

Credentials Committee with responsibility to review applications for appointment to the medical staff with recommendations of privileges to be granted to each medical staff member.

Joint Conference Committee to serve as liaison among the medical staff, governing body and administrator to provide channel for medico-administrative advice.

Medical Records Committee to review quality of patient care provided in the hospital by supervision of the maintenance of medical records at the required standard of completeness.

Medical Audit and Tissue Committees review and evaluate the quality of medical care provided all categories of patients on the basis of documented evidence.

Utilization Review Committee review hospital admissions with respect to the need for admission, length of stay, discharge practices and evaluation of the services ordered and provided with particular emphasis on the appropriateness of use of the facility and its services.

Infections Committee review inadvertent hospital infection potentials and cases and promotion of preventatives and corrective programs.

Pharmacy and Therapeutics Committee who carry out surveillance of pharmacy and therapeutic policies and practices to assure optimum utilization with the minimum potential for hazard.

These committees have a responsibility to report their findings and recommendations to the Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff carries out these functions under the direction of the Medical Staff by-laws of the institution which reflect the approved structure for the Board of Trustees of the institution to fulfill their corporate responsibility to the community.

Against the activities of these organizations in influencing the effectiveness and efficiency of delivery of health care services there is a wide range of activities carried on by financing agencies, such as Blue Cross, both in our role in the private market and also as an Intermediary under the Medicare and Medicaid programs. In this regard our objectives are to influence patterns of care by careful claim review against defined levels of benefits. The broad range of benefits and the depth of definition of each benefit provides the framework for claim review. Some benefits are clearly defined and easily administered, others are not as easily defined and the pattern of care reflected in claim information can represent overlaps and gaps in the patterns of medical practice. The experience under the Medicare program in reviewing the benefit definitions of the extended care facilities clearly demonstrate that care may be medically necessary, but not a covered benefit under the program.

The claim review carried on by financing agencies are supported by professional standards and professional review, either by salaried physicians; the services of institutional utilization review committees or under agreement with county medical societies.

To remove beneficiaries of the various titles of the Social Security Act from the peer review activities of institutional providers or financing agencies and turn them over to a new untested organization would seriously diminish the effectiveness achieved through these review programs serving both public and private beneficiaries and subscribers.

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Further, physician services and the resulting costs are not simply professional judgments. The sum total of these decisions become questions of public policy and the need is for affirmative and accountable public and managerial action rather than a narrowing of the decision-making to professional societies.

It is important to have professional judgment and more physician concern with issues and we by no means deny the importance of this. Indeed, we need to find more ways of getting physicians involved in hospital management and the broader aspects of health administration. It is essential, therefore, that we encourage greater involvement of the professional in standard setting.

There are many aspects of this amendment which can support existing patterns of review. These include:

(1) the development of regional standards of care;
(2) substitution of a more workable system of recertification;
(3) use of the standards of care as a screening device; and
(4) the development of experiments where organized delivery systems can offer their services on an underwritten basis.

We would urge that the amendment be modified so that the function of professional standards review organizations be directed at the establishment of standards and norms to be used by institutional providers in their review activities as well as financing agencies in their claim review activities. The professional standards review organization should also be available on an appropriate agreement basis to substitute for the gaps existing in review in such areas as home and office care, or, extended care and home health services. The amendment already recognizes the difficulties in developing capability of such organizations where there is no existing expertise, staff, systems or data gathering techniques, among others. It should also be understood that the development of professional standards, acceptable to the medical profession, will be slow and expected results would be limited to the establismment of ranges around which those administering review functions would operate.

Thank you Mr. Chairman for this opportunity to present these viewpoints for Blue Cross.

Senator ANDERSON. Have you any questions?

Senator BENNETT. I have three questions.

Are you aware that the president of the Blue Cross Association, Mr. McNerney, has publically and privately acknowledged hospital overutilization?

Mr. TRESNOWSKI. Yes, sir, I am, sir.

Senator BENNETT. For example, the Health Insurance Benefits Advisory Council minutes report Mr. McNerney as replying in the affirmative to the contention that "where bed space is available patients are admitted to hospitals for rest rather than medical care."

Mr. TRESNOWSKI. That is correct, Senator Bennett. Mr. McNerney did a rather extensive study in the State of Michigan on hospital and medical economics where through some scientific approaches he was able to identify substantial overuse as well as substantial underuse.

Senator BENNETT. In your statement you describe an elaborate structure of hospital review committees. Form is one thing. Substance is another.

Can you please provide for the record specific evidence of widespread effectiveness of those internal hospital review committees in each of the 70-plus Blue Cross plan areas?

Mr. TRESNOWSKI. The existing peer review mechanisms in institutional providers and financing agencies represent the state of the art as far as approaches to improve the effectiveness and efficiency of care. One of the provisions of the law, section 1862(a)(1), calls for disallowance of care which is unreasonable and unnecessary. The major difficulty in the administration of that provision is that we do not have adequate standards of what constitutes medical necessity, and

if institutions are working in the absence of some standards for institutional procedures, they cannot effectively do their job. Neither can the financing agencies, so we do not have evidence, good evidence, that institutional providers or financial agencies, including ours, have done an effective job in this area. That is why we recommend to you that the professional standards review organization take on as its primary function the establishment of a regional or other basis standards of what constitutes medically necessary and unreasonable and unnecessary services.

Senator BENNETT. I think that is implicit in the amendment. It has to be done on a regional basis.

Mr. TRESNOWSKI. I agree.

Senator BENNETT. To have any particular and necessary effect.

Dr. Angelides, appearing before the Senate Judiciary Committee in April, said among other things:

> To minimize misutilization of the hospital requires a great deal of work and changes in current practices, but it is worthwhile when you consider that 30–35 percent of the patients in acute short-term general hospitals do not need to be in this type of costly facility.

This is a very large sum of money which can be used to provide more health services in the community. Do you have any comment on that estimate of Dr. Angelides?

Mr. TRESNOWSKI. No, I have heard his estimates. And I have also heard other estimates that range as high as 60 to 65 percent, Senator Bennett.

Again, one really never knows what the effectiveness or use of a hospital is until there are established criteria of what constitutes effective use. In the Michigan study that Mr. McNerney did, he identified 18 diagnoses and put together panels of physicians to establish criteria for effective use of the hospital over these 18 diagnoses. Now you have the standards, now you have the criteria against which you measure and you can then specifically know whether the use is proper or not.

Senator BENNETT. I think implicit in this bill is the development of similar standards on a regional basis.

Again, I agree with you, if you don't have standards and norms or some kind of basis for measurement, you can't operate this system——

Mr. TRESNOWSKI. That's right.

Senator BENNETT (continuing). Effectively under any circumstances.

Mr. TRESNOWSKI. And all we are asking is that the primary function of this professional standard review organization be the establishment of some standards but not substitute for existing peer review mechanisms. Rather than substitute for these existing mechanisms, we ought to have a variety of approaches to control the cost and use of quality care.

Senator BENNETT. That's right. It is my understanding where these local and existing mechanisms are effective, we will expect the new peer review organization to include them or work with them or base their studies on them. But they have the primary responsibility. If we are having ineffective utilization from 30 to 60 percent, then there is a wide open field for careful restudy from a new point of view of this whole question of hospital overutilization. I have nothing further,

Senator ANDERSON. Thank you very much.

(The following communication was subsequently received by the committee:)

BLUE CROSS ASSOCIATION,
Chicago, Ill., September 25, 1970.

Hon. RUSSELL LONG,
Chairman, Senate Finance Committee, New Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: The Blue Cross Association Senior Vice President, Bernard R. Tresnowski, testified before your Committee on September 17, 1970 with respect to H.R. 17550. However, it was not until September 21, 1970 when the Honorable Meade Whitaker, Tax Legislative Counsel of the Treasury Department, testified before the Committee that we were aware of the substance of the Treasury Department's recommendations on information reporting of payments by third parties to providers of health care. We, therefore, appreciate the opportunity to offer this additional statement concerning the Treasury's recommendations which would require a broad extension of information reporting by carriers and other organizations, including Blue Cross Plans, which make health care benefit payments.

The vast bulk of payments by Blue Cross Plans are made directly to hospitals and related institutions pursuant to contracts between the Plan, its subscribers, and member hospitals. A small balance of Blue Cross payments are made directly to the subscriber-patient. The Treasury Department has cited no alleged evasions with respect to hospitals and related institutions, whether they be tax exempt or non-exempt, and does not appear to be concerned with payments to other than doctors. We do not believe that a reasonable need for hospital payment information exists. Until now, under IRS regulations, no report of payments to incorporated institutions has been required. Indeed, even the Treasury Department's current proposals would exclude payment to tax exempt organizations.

The Treasury Department's new recommendations, while not entirely clear, seem to indicate that for both assigned and unassigned payments, carriers are to report the amount of provider charges and the extent of reimbursement by carrier payments. In view of co-insurance and deductible provisions of health care contracts and provisions which exclude payment for specified health services, such reporting would likely yield information to the Internal Revenue Service of dubious accuracy and value. Further, since there is no assurance that the reimbursed patient paid the provider, the information reported might well be misleading.

While the cost of implementing Treasury's new recommendations has not been fully estimated, if only one facet of the recommendations is considered, the high cost is apparent. Where a patient submits bills for health care, the carrier is seemingly not required to report payments to the patient but to determine the identity of each provider and his charges and to report those over specified amounts and aggregate such charges. The amount of paperwork would be enormous. The report of the Task Force on which a Blue Cross representative served discusses these and other important aspects of information reporting in detail.

Each of the 74 Blue Cross Plans operating in the United States is non-profit and tax exempt under Section 501(C)(4) of the IRC of 1954. Increased costs incurred by reason of complex reporting requirements can only result in increased rates for all Blue Cross subscribers. We urge that this burden be not increased by onerous requirements which might well produce information of doubtful utility.

We stand ready to assist in the formulation of necessary, reasonable and well-considered reporting requirements.

Respectfully submitted.

GEORGE HEITLER,
Vice President, Legal Counsel, and Corporate Secretary.

Senator ANDERSON. The meeting will adjourn now and meet at 10 o'clock Monday morning.

(Whereupon, at 12:55 p.m., the committee was adjourned until 10 a.m., Monday, September 21, 1970.)

SOCIAL SECURITY AMENDMENTS OF 1970

MONDAY, SEPTEMBER 21, 1970

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

The committee met, pursuant to recess, at 10:20 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Williams of Delaware, Curtis, and Jordan of Idaho.

The CHAIRMAN. The hearing will come to order.

On July 1, 1969, the Committee on Finance took testimony with respect to the nonapplication of the statutory requirements that payors of amounts of more than $600 per year must report those amounts to the Internal Revenue Service, together with the identification of the payee.

This general rule applies to all situations where the payments involved are made in the court of a trade or business. The committee was shocked to learn that even the Department of Health, Education, and Welfare, which administers massive medicare and medicaid programs, were not furnishing the tax collector with information regarding large payments made to providers of health services under those programs.

As a result of our concerns, the committee added a provision to the Tax Reform Act of 1969 calling for information reports by insurance companies and governmental agencies making health care payments aggregating more than $600 per year. At the same time, the committee made available to the Internal Revenue Service information it had collected with respect to persons receiving more than $25,000 under these programs in 1968.

The committee amendment was deleted from the Tax Reform Act in the conference with the House. One reason for its deletion was the fact that the Internal Revenue Service had, subsequent to the action taken in the Committee on Finance, issued a ruling announcing a change in its policy.

Under the new policy, direct payments—those made directly to the provider of health care services by insurance company pursuant to an assignment by the insured patient—were required to be reported to the Internal Revenue Service in the future. The ruling did not deal with payments made by the company to the insured patient.

This morning, the committee will hear spokesmen from the Treasury Department with further respect to this reporting matter. I am advised that for several months the Internal Revenue Service has

engaged jointly with the insurance industry in an investigation of reporting of medical care payments.

Permit me to say that, insofar as this abuse continues to exist, it is not the fault of the Commission on Finance or of the U.S. Senate. If it were to be defended, I think it would have to be defended by the House Committee on Ways and Means which declined to go along with the provision that was put into the law or at least put into the bill by this committee and by the U.S. Senate.

Our first witness this morning will be the Honorable Meade Whitaker, tax legislative counsel of the Treasury Department. He is accompanied by Mr. Jerry L. Oppenheimer, associate tax legislative counsel. Mr. Whitaker, you are recognized and will you proceed, sir.

STATEMENT OF HON. MEADE WHITAKER, TAX LEGISLATIVE COUNSEL OF THE TREASURY DEPARTMENT; ACCOMPANIED BY JERRY L. OPPENHEIMER, ASSOCIATE TAX LEGISLATIVE COUNSEL

Mr. WHITAKER. Mr. Chairman and members of the committee, I am pleased to present to the committee the views of the Treasury Department on the need for additional legislation to require insurance companies and others to file information returns with the Internal Revenue Service with respect to the amount of payments made directly and indirectly to doctors and other health care providers.

During consideration of the Tax Reform Act of 1969, the Committee on Finance adopted an amendment designed to broaden the existing statutory information reporting requirements covering health care payments. This provision, which would have required insurance carriers to file information reports with respect to payments made directly to health care providers as well as to insured individuals, was deleted by the conference committee.

Our continuing study of this problem has confirmed our view that more effective information reporting of health care payments is essential. We have also concluded that it can only be accomplished by legislation.

The background of this problem is cogently set forth on pages 145–149 of the report dated February 3, 1970, of the staff to the Committee on Finance entitled, "Medicare and Medicaid—Problems, Issues, and Alternatives." The Internal Revenue Code provides that every person making payments of certain types in the course of his trade or business to another person, amounting to $600 or more in a calendar year, must file an information return showing the amounts paid and the name, address, and identification number of the recipient. However, until late in 1969 the Internal Revenue Service did not apply the information return requirements to payments to doctors, dentists, and other suppliers of health care services.

This matter was reconsidered last year and on November 13, 1969, the Internal Revenue Service announced the issuance of Revenue Ruling 69–595 (1962–2, Cum. Bull. 242). That ruling applied section 6041 of the Internal Revenue Code to insurance companies, including those participating in medicare, Blue Cross-Blue Shield organizations, State agencies participating in the medicaid program, and unions and em-

ployers having self-insured or self-administered plans. The ruling requires these payers to file the form 1099 information return with respect to payments aggregating $600 or more annually made directly to doctors and other health care providers. Direct payments are sometimes described as assigned payments. Under this ruling, no return is required for or with respect to amounts paid as reimbursement of amounts paid or payable to a provider. These payments are known as indirect or unassigned payments.

For insurers under the Government-sponsored health care programs, the ruling applies to payments made after January 1, 1969, except that in the case of carriers whose accounting systems were not geared to retrieving and reporting information on payments made in 1969, the ruling applied only to payments made on and after January 1, 1970. An additional 1-year extension was granted to payers not under medicare and medicaid programs, so that the ruling will not be fully effective until January 1, 1971. The prospective application of the ruling was in response to the representation of many insurers that a reporting system could not be installed within a shorter leadtime without undue cost. The year's extension was used, in part, for a study by a joint Internal Revenue Service/insurance industry task force of the systemic and procedural aspects of information reporting. I am pleased to present the committee with copies of this task force report.

The staff of the Senate Finance Committee and the Internal Revenue Service have separately concluded that information reporting of health care payments, as authorized by present law, leaves a good deal to be desired. Chief among the defects, in our judgment, is the absence of a reporting requirement for unassigned payments for health care services.

At present, unassigned payments account for approximately 60 percent of all payments made by commerical carriers, other than Blue Cross and Blue Shield. Aside from this large gap in information reporting, the omission of unassigned payments may lead to massive shifts in billing practices by providers of health care services seeking to avoid the impact of information reporting, including the cost to the payer. Such a shift would increase the information reporting gap. It would also tend to have serious implications for those patients who may be without sufficient financial resources to pay medical costs prior to reimbursement under health insurance. This is, of course, the group for whom health insurance is most necessary and for whom the present trend toward assigned payments is most beneficial.

The Treasury Department recognizes that the 1969 revenue ruling, in its application to assigned payments, has certain deficiencies and inadequacies. These result in part from provisions of existing regulations and in part from lack of statutory authority. For example, reporting is not required of payments to corporations, such as professional service corporations. We believe this problem can be corrected administratively.

The ruling does not impose a reporting requirement upon payees acting as conduits. For example, many clinics or associations of doctors may designate a single individual to receive payments for services by each member of the group. The reporting of large payments to such an agent or nominee without a requirement for a further report-

ing of his redistribution of the payments makes the information less beneficial to the Internal Revenue Service. Also, the ruling omits a requirement that the payers furnish copies of information returns to the payees, which, of course, is an eminently desirable aspect of information reporting.

Except for extending the reporting requirement to corporations, it is, at best, uncertain how far the Internal Revenue Service can achieve administrative solutions to these problems. In fact, it has been suggested that there is some question as to the statutory authority for the issuance of this ruling. And, in any event, it is clear that legislation is needed to authorize information reporting with respect to unassigned payments.

Unassigned payments present a somewhat different information reporting problem than assigned payments. Since an assigned payment is paid directly to the health care provider, it is that amount which is useful to the Service. In the case of an unassigned payment, it is not the reimbursement to the insured which is significant but, rather, it is the separate charges for health care which provide the Service with useful information. Thus, information reporting with respect to unassigned payments requires classification, storage, and retrieval of the various charges to the payee by the health care providers.

We are aware of the concern expressed by the insurance industry with respect to the costs of implementing a reporting system with respect to the full amount of unassigned payments. However, prior cost estimates were based on the reporting of all payments to health care providers aggregating $600 or more in a single year. That would require classification, storage, and retrieval of data on all such reimbursed charges. The major influence on the cost is the number of items processed.

In an effort to reduce the burden on the payers without materially reducing the value and usefulness of the information furnished, we are proposing a reporting system based on the amount of each statement rendered by a provider included in a claim with respect to which reimbursement is made. For the first 2 years, separate statements under $100 would not be reported. This amount would drop to $50 for the succeeding 2 years, after which it would be fixed at a floor of $25. This would mean, for example, that as the insurance carrier analyzed each claim, it would eliminate for reporting purposes during the first 2 years every separate statement under $10. We believe that this approach, which requires the collection and retrieval of significant transactions only, rather than all amounts aggregating at least $600, together with the transitional phasein, will materially reduce the burden on the insurance industry while providing the Service with an important aid to compliance.

Questions have also been raised as to the ability of the Internal Revenue Service to use effectively the information required to be furnished. We fully concur with the view that neither taxpayers nor the Internal Revenue Service should be burdened with returns or documents which serve no useful purpose. However, experience has demonstrated that information reporting can effect an almost miraculous reversal of a series deficiency in voluntary reporting of income.

The statistics of income reveal that, from 1960 to 1963, the number of individual income tax returns reporting interest income increased more than 100 percent, from 10.3 million to 21.4 million, while the dollars of reported interest income increased from $5.1 million to $9.2 million. During this same period, the number of returns filed increased less than 3 percent and adjusted gross income about 10 percent. The important event during that period was that the level of information reporting on interest was reduced from $600 to $10 per year. The conclusion which can be drawn is obvious. Information reporting on items of income has a direct and beneficial effect on voluntary reporting for income tax purposes.

That there is a need to improve the level of compliance in the reporting of health care payments is also clear. During the past year, the Internal Revenue Service has processed returns of about 11,000 physicians receiving medicare and medicaid payments. Preliminary results indicate a number of instances of substantial, unreported income, including some where the omission exceeded $100,000. This confirms other indications of noncompliance on the part of health care practitioners.

The salutary effect on the level of voluntary compliance resulting from commencement of information reporting is too well demonstrated in other areas to require justification. Moreover, the availability of the information itself, even to the limited extent provided by the 1969 revenue ruling alone, will measurably assist in efficient and effective utilization of revenue agent man-hours assigned to the audit process. However, for the reasons already stated, reporting should not be limited to the narrow scope of this revenue ruling. Neither should any doubt as to the authority of the Internal Revenue Service to enforce reasonable information reporting requirements be permitted to exist.

If this legislation is enacted, arrangements will be made by the Internal Revenue Service to match data from the information returns against the individual master file to detect those providers of health care services who have failed to file an income tax return. The data will also be associated with individual tax returns selected for audit in the regular classification process, which will, as stated, improve the ability of the agent to effect a thorough and speedy audit. In addition, it is anticipated that analysis of the information from the various programs utilizing these documents will lead to the identification of special return selection criteria which will facilitate the selection of high-yield returns for audit. These factors together will contribute substantially to the ability of the Internal Revenue Service to maintain its responsibility in the compliance area.

The need for this legislation is clear. An effective information reporting system is probably the strongest available incentive to support the voluntary reporting of income. Where it becomes feasible, as now in the case of health care payments, it should be adopted. Accordingly, I am recommending to the committee legislation similar to section 944 of H.R. 13270, as reported out by this committee in 1969 but deleted in conference, modified as I have indicated.

I would now like to discuss in more detail our specific recommendations.

1. AUTHORIZATION

(*a*) Information reporting by insurance companies, Blue Cross-Blue Shield organizations, medicare and medicaid agencies, employers, and unions operating health insurance plans and similar payers with respect to unassigned payments should be authorized:

(i) Reporting should be made annually of the amount of each health care statement in excess of the specified minimum amount with respect to which a payment is made, with all charges by each separate provider reflected by such statements aggregated for the year;

(ii) Reporting should commence with respect to charges reimbursed after December 31, 1971;

(iii) For the years 1972 and 1973, the reporting should exclude all statements less than $100; for the years 1974 and 1975 all statements less than $50; and thereafter all statements less than $25 should be excluded;

(iv) Reporting should not be required with respect to any charge on account of health care services furnished by an instrumentality of the Federal Government or by any State or local government or by any tax-exempt organization;

(v) The $600 floor of existing law should not apply.

(*b*) Information reporting by the same group of payers of assigned payments should similarly be authorized, with the same exclusions phased in during the same periods, except that such reporting should be commenced at the $100 level for all assigned payments made on and after January 1, 1971. Each separate payment in excess of the excluded amounts to each payee should be aggregated and reported annually.

2. COPIES OF INFORMATION RETURNS

Copies of information returns should be supplied to each payee in the case of assigned payments. In the case of unassigned payments, each provider of health care services with respect to whom an information return is filed should be furnished a copy of the return.

3. NOMINEE REPORTING

A further reporting requirement should be imposed on each health care provider who receives any payment in excess of the prescribed amounts which such provider is obligated to disburse to one or more other providers.

4. SEPARATE PAYMENTS FOR MERCHANDISE

Reporting should not be required with respect to any separate payment—assigned or unassigned—for merchandise or property such as drugs, eye glasses, prosthetic devices, wheelchairs, beds, crutches and the like.

5. EXCLUSION OF TORT CLAIMS

Payments in settlement of tort claims shall not be subject to information reporting under this provision even though such payments may include amounts referable to the cost of health care services.

The Treasury Department strongly supports the need to clarify and extend the information reporting requirements applicable to health care payments. I appreciate the opportunity to appear before the committee on this matter. My staff and I will be happy to answer any questions the committee may have.

The CHAIRMAN. Let me just ask a question or two.

We have a pamphlet of staff data showing examples of health care practitioner with substantial unreported income that we may release after the committee has had a chance to discuss it We will decide whether we should release it. For this discussion we will make it available to you. Look at example No. 30. Here is a case where for years; 1966, 1967, 1968 there was an income determined of $158,591, and an income reported of $18,590.24. That left income of $140,000 unreported. I take it that was the income on which this doctor had not reported and on which the Government was not receiving its taxes. Would that be correct?

Mr. WHITAKER. That is correct, Mr. Chairman. I should say that these cases have not been finally disposed of. They are the results of our preliminary investigation.

Senator CURTIS. This is No. 30.

The CHAIRMAN. Thirty, example No. 30.

Senator CURTIS. Would my chairman yield for just one question? How many of these involved were insurance payments?

Mr. WHITAKER. All of these cases, Senator Curtis, came from medicare and medicaid so they all involve that type of insurance.

Senator CURTIS. Then the answer is none of them involve insurance?

Mr. WHITAKER. None of them involved the private insurance sector.

Senator CURTIS. That is who is on trial here. If insurance companies are asked to report——

The CHAIRMAN. The Senator is getting ahead of me. I don't mind somebody trying to anticipate what I am trying to say but sometimes one makes a mistake. I wasn't going to say that at all.

Senator CURTIS. All right.

The CHAIRMAN. Do I take it that that doctor did not report that $140,000 and didn't pay taxes on it?

Mr. WHITAKER. That is what our preliminary investigation discloses.

The CHAIRMAN. Now, assuming that to be correct, why don't you prosecute him criminally?

Mr. WHITAKER. Well, the cases are still under investigation and if there is a case that will justify a criminal fraud prosecution, it will be carried to that point, sir.

The CHAIRMAN. All right.

As an alternative to providing the kind of law that we sought to provide in this committee, and which the insurance companies have opposed, it might be argued that if you would spot check, let's say 20 percent of these returns and, where you find an example like No. 30, prosecute him criminally, and if you don't put him in the penitentiary, at least try, that that would be a very great deterrent on doctors engaging in that kind of conduct in the future. What is your reaction to that?

Mr. WHITAKER. Well, it is certainly true, Mr. Chairman, that criminal prosecution for tax evasion has a very salutory effect but that re-

quires a great deal of evidence which is sometimes not available, and from the standpoint of the voluntary reporting of income the whole system on which our income tax is based, we feel that information reporting is a much more effective tool. It enables the revenue agents to more effectively audit a return which may or may not have tax error aspects in it.

The CHAIRMAN. In other words, your thought is that that is a poor substitute for simply asking the Department of Health, Education, and Welfare in one instance or private insurance companies in the other instance simply to provide you with the information of who are the doctors receiving these payments.

Mr. WHITAKER. That is correct. It is very worthwhile to have even this amount of information, but it does not adequately cover the problem, in our judgment.

The CHAIRMAN. If that same doctor knew that that $140,000 was to be reported on information returns and he would be hearing from Government Revenue Agents about the $140,000 that he failed to report, what effect do you think that would have upon that doctor?

Mr. WHITAKER. Well, I think obviously, Mr. Chairman, that would be a strong incentive to report the income initially, which of course is the way that the system ought to work.

The CHAIRMAN. In other words, if a fellow thinks he is going to get caught the probabilities are that he will go ahead and report it, to begin with?

Mr. WHITAKER. That's right.

The CHAIRMAN. If he thinks he might get away with it, he is likely to fail to report it.

Now, we undertook to obtain examples of doctors who had been paid $25,000 or more from HEW and we finally obtained them.

What did you do with that information when we provided it to you?

Mr. WHITAKER. These 11,000 returns were furnished to us last year, Mr. Chairman.

The CHAIRMAN. Yes.

Mr. WHITAKER. We distributed those returns to our IRS centers, and located all of them that we could. We were able to locate practically all of the returns. They were then scanned, analyzed and we picked out of the total about 4,000 which the revenue agents in the normal process felt justified detailed audit.

We already have preliminary results on something better than 3,000 of the 4,000 returns. These preliminary results of the audits included those cases which we furnished you and which the chairman referred to a moment ago.

As a matter of preliminary information it looks to us as though about half of the 3,000 that we audited will come up with substantial deficiencies.

The CHAIRMAN. If they are going to make a lot of money out of the program, and charge higher prices, they at least ought to pay us the taxes that are owed on that.

Now last November, after the committee acted to add a reporting requirement for medical payments to the statute, the Internal Revenue Service issued a ruling requiring reports of the same sort of payments. This ruling was an important reason why the committee amendment was deleted from the tax reform bill in conference with

the House of Representatives. Was the ruling as broad in its coverage as the Senate amendment?

Mr. WHITAKER. No, Mr. Chairman, the ruling was not that broad. One major difference is that we do not feel we have the statutory authority to require reporting of unassigned payments. That ruling was limited to assigned payments.

The CHAIRMAN. Is the suggestion that you make here today as broad as that 1967 Senate committee amendment?

Mr. WHITAKER. It is substantially as broad. It varies in some relatively minor respects, Mr. Chairman.

The CHAIRMAN. Now, in the transmittal letter to the chairman from Commissioner Thrower transmitting a series of illustrations of abuses by health care providers, the Commissioner mentions that these cases are ones which have been referred to the Intelligence Division of the Internal Revenue Service. Are there other cases which have not been referred to the Intelligence Division for one reason or another in which sizable amounts will be recovered because of data that was supplied?

Mr. WHITAKER. Yes, Mr. Chairman. The Intelligence Division handles only those cases where there is tax fraud. All of the cases were initially reviewed by our regular audit process and those which weren't referred to the Intelligence Division are being handled by revenue agents as part of the normal audit.

The CHAIRMAN. The American Medical Association previously indicated to this committee that it had no objection at all to routine reporting of payments for physicians' services. In essence then this organization indicated that doctors should be treated just as other taxpayers are treated in terms of income tax reporting. Has the Internal Revenue Service encountered any contrary position expressed by organized medicine?

Mr. WHITAKER. No, Mr. Chairman; the American Medical Association has made no representations to us at all.

The CHAIRMAN. The American Medical Association, so far as this Senator can tell, from an ethical point of view on taxes, has been completely forthright and honorable and sought to shield no one. In fact, I believe some segments of the AMA have actually requested us to provide them examples or evidence of tax cheating, or overcharging as the case may be, so that they could take action.

Apparently the opposition to information reporting is coming from the insurance companies, is it not?

Mr. WHITAKER. I think that is correct, Mr. Chairman.

The CHAIRMAN. Well, the cost to the insurance company for tooling up to make information reports to the tax collectors apparently was a significant factor that contributed to the defeat of the Senate amendment in 1969.

Have you investigated this matter, and if so, what comment can you make?

Mr. WHITAKER. As I stated in my prepared testimony, Mr. Chairman, we are concerned about the cost burden on the insurance industry. Our proposal will, we believe, substantially lessen that cost.

The cost, as we understand it, is a direct factor of the number of items handled, and our proposal reduces very materially the number of items that the insurance industry will have to process in connection with the information reporting.

We would also anticipate utilizing our regulatory authority to implement the statutory provision as to reduce as far as possible in every respect the cost burden on the industry.

The CHAIRMAN. I understand that following deletion of the proposed 1969 amendment the Treasury engaged in a long study, in cooperation with the insurance industry, of problems association with the reporting requirement. Do I understand correctly that your request letter today is based on this joint study?

Mr. WHITAKER. Yes, Mr. Chairman. Our recommendations for modifications in the reporting of assigned claims are based substantially on the joint study.

The CHAIRMAN. Can you tell us what the attitude of the insurance companies might be with respect to the legislation you are recommending to the committee here today?

Mr. WHITAKER. I think it is obvious that the insurance industry will be very much opposed to it because of the cost burden they feel would be imposed on them. However, the cost estimates with which we are familiar were based on the amendment that was proposed by the Finance Committee last year. We have not seen any cost estimate based on our changed proposal but we do feel that there is every reason to believe the cost burden will be substantially reduced.

The CHAIRMAN. If this is a vast area of tax cheating, then it seems to me that the insurance companies should not permit themselves to be put in the position of shielding doctors while those doctors engage in wholesale cheating on taxes against the Government. I would hope that we would have the cooperation of that great industry in working out some method of collecting these taxes.

There is a large move today toward establishing professional corporations for the practice of medicine. These corporations, for the most part, are organized for the purpose of getting around the self-employed retirement limitation under H.R. 10. How does your recommendation for information returns apply to these corporations?

Mr. WHITAKER. The requirements would apply where the professional corporation is the payee, and the beneficial owner of the income just as do other corporations except for tax-exempt corporations. There would be further reporting if the professional corporation were a nominee or a conduit. The reporting requirement then is on the professional association.

The CHAIRMAN. It is my understanding that since we reported in 1968 those doctors receiving more than $25,000 in payments under medicare, the numbers of doctors receiving $25,000 or more, has nearly doubled. Has that been in accord with your information?

Mr. WHITAKER. Yes; I believe that is in accordance with our information, Mr. Chairman.

The CHAIRMAN. Well, thank you very much.

Senator Williams?

Senator WILLIAMS. First, Mr. Whitaker, I want to thank you for your testimony and state that as one member of the committee that I want the Treasury to have whatever information is necessary in order to do its job.

But to get the record straight, are all the objections to this proposal coming from insurance companies or did some of it come from the Government agencies that were administering similar programs?

In other words, what cooperation have you had in the past from medicare and medicaid in connection with this reporting?

Mr. WHITAKER. In our experience, we have had reporting under our 1969 ruling.

Senator WILLIAMS. But prior to that—how long have you been aware of this discrepancy in reporting? Did you know about it before our committee began investigating this about a year ago?

Mr. WHITAKER. Yes; we knew that when the committee adopted the amendment last year and we supported it.

Senator WILLIAMS. I know that, but is that the first time you knew you were losing revenue as a result of nonreporting by these professions?

Mr. WHITAKER. Well, I think all of our studies in recent years have tended to indicate that there is a revenue problem, a voluntary compliance problem in this area.

Senator WILLIAMS. That was my understanding. I know that when our committee was going into it we received rather strong objections from the HEW people administering both medicare and medicaid. When we suggested they use social security numbers for payment of the doctors, they said they hadn't thought of it before and then they said that when they did think about it they thought it would be troublesome. You are requiring that under this November 1969 ruling, is that not correct?

Mr. WHITAKER. Yes; that is correct.

Senator WILLIAMS. Now, both medicaid and medicare must use the social security number in reporting, is that correct?

Mr. WHITAKER. Yes, sir; they have to use it in reporting to us.

Senator WILLIAMS. Why wasn't that requested sooner if you had the authority to request it under existing law? As one member of the committee, I thought we had required that. Why was the Government itself lax in following rules that it laid down for everybody else? As I understand it, the particular case No. 30 that the chairman referred to involved medicaid and medicare payments which this committee called to your attention and which would have been called to your attention had they endorsed the requirement of using social security numbers, is that true?

Mr. WHITAKER. Yes; that is true, Senator Williams.

This is a matter which has been under study by the Internal Revenue Service and the Treasury Department for a number of years. It has had problems which all of us have recognized. Among other matters, there have been questions in the past as to the extent of our statutory authority.

I think, perhaps more important, the ability to utilize the information is in part a function of the development of data processing. A number of years ago the burden would have been almost staggering both on the Service and on the industry. However, we believe that we have now arrived at a position where we can effectively utilize the authority, and, therefore, we think it appropriate to do it now.

Senator WILLIAMS. The reason I mention this is because I think it should be clear, that, whatever is necessary for you to get information whether it involves insurance companies or not should be supported. I supported similar proposals before and I was sorry we didn't work out something in conference.

But I don't think we should let the record stand that the insurance companies are the largest culprits because the largest payers, the largest group making payments to these doctors involving hundreds of millions of dollars are the medicaid and medicare programs, which have refused to cooperate with the Internal Revenue Service and, as I understand it, refused to furnish to the Internal Revenue Service access to their books relating to the amount of money being paid to Joe, Tom, Dick, or Harry. I think you got the information after we got it from the Department and we relayed it to your department. You were unable to get it from the Social Security Administration itself, is that correct?

Mr. WHITAKER. I am not personally familiar with that aspect of the problem. May I ask my staff about it?

Senator WILLIAMS. We were so advised at the time, and I thought it was rather reprehensible. You find a situation where a Government agency making such payments would refuse to cooperate on a provision which we were trying to apply on everybody else. I think they should have set the example rather than dragged their feet as they did. I understand Social Security didn't even have the information.

Mr. WHITAKER. We had full cooperation from the Social Security last year when the matter came before the committee. Prior to that time, I am not sure that the blame should be placed entirely on Social Security. There have been problems in working out both their system and our system to accommodate the handling of the information, and in getting the numbering straightened out. I think we have now accomplished that.

Senator WILLIAMS. I won't get into trying to settle whether it was their fault or your fault in not getting the information, but the fact was that this information was not available. I was the one who proposed that if they didn't make it available to you forthwith we would write it in the law and we would replace any Government official who refused to cooperate with the Internal Revenue Service and I think they decided they could cooperate. I was just surprised that Social Security was giving these doctors numbers and had a staff just dreaming up Swiss bank account numbers or whatever, specifically so the Internal Revenue Service couldn't identify the doctors. I think it was wrong for a Government agency to be doing that. I think that is where the criticism belongs.

Are you getting the information today under this regulation on payments that are made by medicare and medicaid through the carriers?

Mr. WHITAKER. Yes, Senator Williams, we are getting that information now.

Senator WILLIAMS. From all the carriers making medicare and medicaid payments?

Mr. WHITAKER. We postponed the reporting from the private carriers until 1971 because there were some carriers who would have had trouble working out their systems to pick up the payments for reporting purposes sooner than 1971.

Senator WILLIAMS. Now, on the Government health insurance programs that are operating today, are they giving you a breakdown of these payments comparable to what you would get if we passed this law?

Mr. WHITAKER. Yes, sir; in substance, the payments that the ruling applied to are only the assigned or the direct payments and the information we are seeking under our law is exactly the same information we are getting under——

Senator WILLIAMS. I am speaking of the information that will be available to you if we enact the legislative proposal. Are you getting the information from the Government insurance programs, Government health insurance programs, today, that you would be getting if we enact your legislative proposals?

Mr. WHITAKER. Yes, Senator Williams.

Senator WILLIAMS. You are getting all of it today, and all you are asking is an extension of that same information to the private health insurance plans, is that correct?

Mr. WHITAKER. And we are asking that it be extended to the unassigned payments as well as to the direct payments.

I should make it clear, Senator Williams, that medicare also makes unassigned payments. Some part of medicare is a reimbursement to the individual.

Senator WILLIAMS. That was my understanding.

Mr. WHITAKER. We do not get any information with respect to unassigned payments at this time from medicare.

Senator WILLIAMS. And you need legislation to make medicare and medicaid give you that information?

Mr. WHITAKER. That is correct, we don't have the authority to ask for that now, sir.

Senator WILLIAMS. Well, this is a Government agency, why aren't they doing it? Then we would have a good test as to just what it costs to do it. Are they complaining that it would cost them too much, too?

Mr. WHITAKER. As far as I know, Senator Williams, I don't think the matter has been discussed in depth with the Social Security people.

There is a further problem beyond Social Security. Without statutory authority I am not sure that even medicare could get the necessary information from the health care providers in order to make the information useful to us.

Senator WILLIAMS. I am not quarreling with your legislative proposal. Don't misunderstand me, I think you need it, but the question that comes to my mind is, Why do we need legislation to make a Government agency comply with information returns that the Internal Revenue Service needs? Certainly Government agencies should cooperate with you.

But my question is, Are they doing it now, the Government health insurance plan programs, and medicaid and medicare? To what extent are you not getting information from those Government agencies administering health programs today, information that you would get if we enacted your bill, and should we spell out particularly that it would apply to the Government itself as well as private industry?

Mr. WHITAKER. To answer the second question first, if I may, Senator, I don't think it needs any special legislation or special language in the committee report. It simply is a function of the legislative program.

The problem, if I can go back to the unassigned cases, is simply that when an insured brings in a claim (and this would be true with the unassigned claims for medicare), the claim of the insured will have

bills attached from a number of doctors. There is no statutory authority to permit us to require that the insured obtain taxpayer identification numbers from the doctor whose bill he has already paid and with respect to which he is now asking for reimbursement. It is in that gap that we need the authority to require the providers of health care services to furnish the social security number, or the taxpayer identification number, so that the information reporting will be useful to us.

Senator WILLIAMS. Yes. But the point I am making is that the medicare-medicaid program, which is entering into a contract with these various carriers, can have it included as part of that contract that they do report all of this information to you, otherwise they get another carrier. The Government won't work through it. That could be done, could it not?

Mr. WHITAKER. Well, that possibly could be done, but I think it puts everybody, even separate government agencies, in the difficult legal position of asking for information which the Internal Revenue Code does not require the individuals to furnish.

Another aspect of this is that if we focused only on the medicare and medicaid payments, we would be singling out one part of the industry for special treatment and for additional costs, and I am not sure that that is an attitude that the Service should take.

Senator WILLIAMS. Well, that is the same argument the Social Security gave us for not using social security numbers and reporting on the doctors. They said nobody else wanted to do it and they didn't want to do it. Later on, they changed their mind and did do it. That particular argument does not impress me.

On page 6 you state:

> For example, many clinics or associations of doctors may designate a single individual to receive payments for services by each member of the group. The reporting of large payments to such an agent or nominee without a requirement of further reporting of his redistribution of the payments makes the information less beneficial to the Internal Revenue Service.

Under the existing system, if the payment is made to Joe Doakes who, we will say, is getting payments of a hundred thousand dollars and is dividing that up with six or eight other doctors; if you use the social security numbers when you make that payment, that doctor, who receives the payment on behalf of all the others, would have to report it under existing law. For example, he would have to report a hundred thousand dollars income from such and such a source, and then claim credit for a breakdown of the payments that he made to various Tom's, Dick's, and Harry's. Is that not the law today?

Mr. WHITAKER. I am not sure, Senator Williams, that the agent would have to be required to report it as his full payment.

Senator WILLIAMS. If it were you or I and someone had paid you a hundred thousand dollars, is that not supposed to appear on our tax return as a hundred thousand dollars income?

Mr. WHITAKER. Not unless we received the income as our own income. I don't believe that the law requires an individual to take in as his own gross income that which he doesn't own.

Senator WILLIAMS. You mean that he can break it down on a piece of paper and note beside and only report that portion of it which is his, and ignore all the other. Is that what you are telling us, because that is not my understanding, and this would apply to a lot of money that is going——

Mr. WHITAKER. It would depend on the legal relationship. For example, if the doctors were members of a partnership, the income would be shown on a partnership income tax return.

Senator WILLIAMS. And the partnership then would file that tax return?

Mr. WHITAKER. Yes, sir.

Senator WILLIAMS. And report it to the various Tom's, Dick's, and Harry's, wouldn't it?

Mr. WHITAKER. Yes.

Senator WILLIAMS. And he would report it by social security number, wouldn't he?

Mr. WHITAKER. Yes, sir.

Senator WILLIAMS. Even under existing law?

Mr. WHITAKER. Yes. A partnership does have to file a regular partnership return.

Senator WILLIAMS. That is right, and how much has been paid out to the respective partners, and they report the social security numbers when they put these payments on the return, is that not correct?

Mr. WHITAKER. That is correct.

Senator WILLIAMS. So you do have that information under existing law if you would use it?

Mr. WHITAKER. That is right, if there is a partnership.

Senator WILLIAMS. All right. There is no partnership filed and you receive payments as a single individual. Are you telling me that if there is no partnership agreement filed that a single individual can collect the money which is due you and me, and only report his part of it. There is no reporting necessary on the part that you and I would get when we collect our two-thirds?

Mr. WHITAKER. I believe there are circumstances, particularly in the medicare or medicaid programs, where it is either necessary or desirable for one individual or one entity to be designated as the payee. If that is simply a matter of convenience, and if that one entity doesn't have any claim to the income, I don't think that we could require in all circumstances that that income be reported on the tax return. We certainly would have no power under present law to require an information return to be filed by that entity.

Senator WILLIAMS. Then an individual collects $30,000 from an insurance company, from medicaid or medicare for doctors services.

There are two other associates with him. It is not a partnership, not a corporation, and each gets $10,000 apiece. All he has to do is to report his $10,000. He has got $30,000, showing up that he was paid using his social security number under this existing ruling. You mean there is no check back in order to find out where this discrepancy is. Because here, medicaid will be reporting, by social security number, the fact that they paid me $30,000. On my tax return you only see $10,000 because that is all I got out of it and I don't tell you where the other $20,000 went. You mean I don't have to tell you anything about it?

Mr. WHITAKER. As a practical matter, Senator Williams, if that tax return were audited and the agent had information of a $30,000 payment, the agent would certainly inquire, and, I am sure, would be entitled to get the information as to what has happened to it.

The insufficiency is that when the return was selected for audit under this arrangement without the information that showed how

the $30,000 was broken down, the return might show a large deficiency which really wasn't justified, and it might trigger a detailed audit, which really was unnecessary.

That is one reason why we are asking for the authority to have another information return which shows the distribution. It means that our processing of tax returns can be made a much more efficient process.

Senator WILLIAMS. Well, to put it another way, I don't want to pursue this much further, if there is any loophole here I certainly want to close it, but we have to recognize it in order to close it. I want to know if a group of individuals makes an investment and they are getting $30,000 a year dividends, and they make their investment by a gentlemen's agreement all in one man's name, and this $30,000 dividend comes to you or me, then you are telling me all I would have to put down is $10,000 of dividends and I don't have to report that 20 went to Tom and 10 went to Joe——

Mr. WHITAKER. Well——

Senator WILLIAMS. There is no requirement under the law to report that?

Mr. WHITAKER. Under many circumstances it would certainly be necessary, if not desirable——

Senator WILLIAMS. Under the specific circumstances that I mentioned, under that particular case would not the law require that I report those two $10,000 payments in order to show why I wasn't putting in the full 30?

Mr. WHITAKER. Well, let me say this, Senator Williams. If that individual reported the full $30,000 in his return, then he would obviously show that he had not retained it. But the difficulty—the gap in our administrative handling of it—is that we would not have an information return on the subsequent distribution. Consequently, in order to track down the full payment, the amount that was redistributed, the agent would have to get in touch with that particular taxpayer and find out what he did with it or would have to examine his return. But, if we have an information return, we can associate all of the information data with any return we are examining and we could then bypass other steps in the process which are not necessary.

Senator WILLIAMS. I understand that, and I just want a straight answer. Does the existing law require that if you have an investment, and it is yielding $30,000 a year in interest or dividends, and all of it is paid in my name, to me, but in turn I have a couple of partners; under the law am I required to report all of it, or just report that portion which I received? You are required to report all of it, are you not?

Mr. WHITAKER. I am sorry, Senator.

Senator WILLIAMS. I say I thought you were required to report all of it and then break it down and take your deductions as to how you paid it out. If you paid a certain amount to somebody you would file a form showing what you paid to them. If it is not necessary, I would say you have a loophole here?

Mr. WHITAKER. If the income belonged to the individual, which might well be the case in the circumstance you posed, then there would be a requirement to report it. It probably would be a partnership situation. In fact, even if there were no formal partnership

agreement, there would be a requirement for a partnership return, since partnership returns are required in any joint venture. That, I believe, would be the analysis of the situation you posed.

Senator WILLIAMS. A partnership return is required, as I understand it, even though there is no partnership formed if it is a joint venture?

Mr. WHITAKER. Yes, sir.

Senator WILLIAMS. Then I will get back to the doctors again. It is a joint venture, is it not?

Mr. WHITAKER. Well, it may be a joint venture.

Senator WILLIAMS. And the money is all paid to one individual as a joint venture, and there are some reporting requirements. What I am trying to establish is, to what extent are you enforcing the law that you have now. I am willing to give you the additional laws that you may need but I don't want you to cover over the fact that this has not been enforced heretofore and I don't want to leave the impression here that the law has been lax. I think there has been a laxity right here in Washington in some of this, that is the point I am getting at. I am sure I have used up too much of my time.

The CHAIRMAN. Go ahead.

Mr. WHITAKER. In fairness, Senator Williams, this whole problem of information reporting of health care payments is something which the Service has been wrestling with for a good many years. I am sure that up to this time we have not exercised all of the authority that we have under the law. Some of these problems are relatively recent developments—certainly the whole health care field is developing and has developed very rapidly, including medicare and medicaid. There are problems which need to be worked out, some of which I believe we could work out administratively to improve the situation.

However, regardless of these administrative improvements, there are gaps in the law which need to be filled to make a complete overall system.

In the situation that concerns the Senator, I think in most instances we would get tax returns which would show the information. But we would not get them in the form of information reporting which would give the Service the maximum utilization of the information with a minimum of expenditure of time and money.

Senator WILLIAMS. Well, I am going to conclude with this, I say again I want you to get what information returns you can and I don't think that your department has had the information that it has needed in the past. But I think part of that has been the lack of cooperation of other Government agencies as well as the lack of cooperation of private industry. It would seem to me that we can justify enactment of a legislative proposal, which, if necessary, I will certainly support, but we can justify it as it effects private industry to a much greater extent if we can show that the Government itself has been living by the rules we are trying to lay down for everybody else. It is this foot-dragging on the part of Government agencies that disturbs me.

Now this is not criticism of the Revenue Department because I know that at the time we were collecting this earlier last year we found a tremendous amount of opposition from the Social Security Agency over their willingness to make available to the Internal Revenue

Service the information which they reluctantly gathered for this committee relating to these payments. They admitted—they never have been using the social security numbers of these doctors so they could identify them. They had no method of identifying these payments, and to me that was just an indefensible position for the Departments to have, I think that all Government agencies should set the example for private industry and while we may need legislation here today, I think we should make it clear that we are trying to clean the Government's house as well as clean up some of the outside, private industry.

Senator CURTIS. Mr. Whitaker, this legislative recommendation which you are making today would apply in case of insurance companies to all of their insured people, not only those who come under medicaid or medicare or some other Government program, is that right?

Mr. WHITAKER. That is correct, Senator.

Senator CURTIS. There are 2 or 300 operations of medicare where there is no intermediary. They deal directly with the Government for reimbursement.

Would you need any new law to require the parties in those situations to give you all the available data that you might request.

Mr. WHITAKER. We do not think that we need statutory authority in that limited area, Senator Curtis.

Senator CURTIS. Including the unassigned?

Mr. WHITAKER. No, Senator Curtis; I do not think we have the authority in the unassigned area unless it is done by contract between the Social Security Administration and the individual providers of health care service.

Senator CURTIS. But there is no intermediary. There are about 2 or 300 situations where there is no insurance company designated as an intermediary to process claims. The Government processes its own claims.

Now, in such a situation does the Government have authority to collect data in reference to unassigned claims?

Mr. WHITAKER. Well, by definition, Senator Curtis, an unassigned claim is an instance where it is not the provider of health care services which has contact with the payer but it is the patient who has the contact with the payer. However, in the situation the Senator poses it is the individual who is entitled to medicare or medicaid. If the patient were to file a claim there would be no direct contact, as I understand it, between medicare and the doctor who provided the health care service. In that situation we do not believe that under the Internal Revenue Code we or the Social Security Administration have the authority to require information reporting.

Senator CURTIS. You said earlier that you needed this authority of a statute to get the data in reference to unassigned claims to meet certain legal requirements. Would you elaborate on that a little bit?

Mr. WHITAKER. Well, the only authority we would have would be to require reporting of payments aggregating $600 or more made in the course of a trade or business. There is a very serious question as to whether, under the reporting requirements, we could require the

average health care insurance company to report a payment which is in reimbursement of an unassigned claim that the payee files.

Even if we had that authority it really wouldn't do us any good because all we would get on that sort of a reporting basis in information, for example, that Metropolitan Life paid John Doe $150 in reimbursement of a health care claim. That is not the information we need. What we need is where that $150 went, what claim it went to pay.

We do not have the authority to require the patient to obtain from his doctor the information as to the bill, to submit it to the insurance company and then to require the insurance company to give us this information. The requisite information is not simply the payment to the patient but it is the amount of the bill that the individual doctors or health care providers filed with the payee to the patient, and that the insurance company is now reimbursing the patient for having paid.

Senator CURTIS. I want to take a hypothetical case where it is an individual of such circumstances where no medicare or medicaid or no Government programs are involved.

I think it is safe to assume that most medical bills add up to more than the individual has insurance.

Let us assume that a holder of an insurance policy has medical expenses and he files a claim and he is paid $1,500 by an insurance company. The insurance company has a contract with the insured. They don't have any contracts with any hospitals or doctors or any drug suppliers. The insurance company decides that under his policy he is entitled to $1,500. He owes a bill to four doctors as well as the hospital and clinic and the like.

From his $1,500 he can't pay all four of them. He pays two of the doctors and pays the hospital. If this becomes the law, will the insurance company be required to report data concerning the two doctors who were not paid at all?

Mr. WHITAKER. Yes, Senator Curtis; our proposal has nothing to do with actual payment to the doctors.

Senator CURTIS. What is it for? What are you going to use this information to check against our master file to make sure that each individual who has rendered services for which he was entitled to payment has filed a tax return.

Mr. WHITAKER. In the circumstances you posed, it is entirely possible that that doctor would have had no income for the year; but it is unlikely, and this will give us a check on the nonfilers.

What it will really do, Senator Curtis, is that with this type of information reporting we will cut down on the number of who failed to file a tax return in this area to a bare minimum. The second thing we will do with the information is to obtain the name of the doctors, even the doctors who in your example did not get paid. We will have those names and we will have an aggregate figure, over and above the minimum, representing the amounts billed by those doctors and forwarded with claims to this particular insurance company for the year.

When one of those doctors' tax returns in the normal order of process gets audited, this information will assist the Revenue agent to conduct an audit of that tax return quickly, efficiently, and properly.

In many instances the information will be sufficient to indicate to the agent either that the tax return as a whole is adequate and proper and in all likelihood has correctly reported income. Therefore, neither the time of the agent not the taxpayer will be taken up.

In other instances this information will be sufficient for a trained agent to realize that there is a very serious discrepancy in the reporting of income, and assign that return to an experienced field agent for detailed audit.

Senator CURTIS. Well, now, Mr. Whitaker, in any other segment of our economy, do you require somebody to report data concerning an amount that is never paid?

Mr. WHITAKER. So far as I know, Senator Curtis, we do not in any other segment, but we know of no parallel for this particular situation.

Senator CURTIS. Now, up until this particular doctor is selected at random for an audit this whole thing will be handled by machines, won't it?

Mr. WHITAKER. Well, we hope basically it will be handled by tape, to enable us to make the most effective use of it and, I think, minimize the difficulties on the part of the insurance company in reporting that information.

Senator CURTIS. Now coming back to my hypothetical question where an insurance company pays $1,500 to an insured and he owes four doctors and the hospital and he pays the hospital and pays two of the doctors. Whose responsibility is it to provide names of the four doctors and their social security numbers?

Mr. WHITAKER. The names of the doctors in the normal case will be furnished as part of the data which supports the insured claim. That data already goes to the insurance company for its present purposes in order to determine how much of the claim should be paid. Thus, the insurance company would have the names of the doctors and the amounts. The only thing missing in that normal circumstance is the taxpayer identification number of the doctor which would have to be put either on the bill or there would have to be a different mechanism worked out to get that information to the insurance company.

Senator CURTIS. But who has to report it to the Internal Revenue Service?

Mr. WHITAKER. Under our proposal, Senator?

Senator CURTIS. Yes.

Mr. WHITAKER. The legal obligation would be on the insurance company, to get the name. There would also be a legal obligation on the provider of the health care services to furnish the information and with those two legal obligations we feel that we will be able to work out flexible ways in which the information can be obtained by the insurance company with a minimum of difficulty. But without the legal obligation, on the one part, to collect it, and, the other part, to furnish it, we would have very serious difficulty in getting the necessary information.

Let me comment on one other thing about your hypothetical, if I may. Mr. Oppenheimer points out to me we are talking about an unassigned claim. The unassigned claim is basically a claim for reimbursement of expenses that the patient has paid. So it would only be in very rare instances according to your hypothetical that doctors would not have been paid.

Senator CURTIS. Why? The check is made to the insured.

Mr. WHITAKER. But, generally speaking, at least this is my information, the insurance company will pay, as a matter of reimbursement to the patient, expenses that he has incurred, not expenses which he anticipates.

Senator CURTIS. He may have incurred the obligation but the insurance company does not assume responsibility under their contract that the insured pay the doctor.

Mr. WHITAKER. That is quite true.

Senator CURTIS. Isn't it also true that in this same identical illness one or two of the doctors submitted a bill to the insured, he attaches it to his claim to the insurance company. They send it in and they look at all these bills from doctors and hospitals to ascertain what their liability is under the policy. It may be that Dr. A performed services for which there was no insurance, and Dr. B performed services for which they were all insured. But the insured in filing his claim to show his entire sickness expense and in order to submit it to the company to see what they are going to do, does it that way. How are you going to distinguish between A and B's bill attached to the claim of the insured so far as tax collections are concerned?

Mr. WHITAKER. Well, our proposal is geared to those claims which a patient would submit with respect to which there is insurance.

If, in the circumstance you posed, an uninsured medical expense were included in a statement, the insurance company under our proposal would have the privilege of ignoring that for information reporting purposes. If it were included in a report it would do no harm. So in essence, I think the insurance company could treat it or not treat it for information or other purposes.

Senator CURTIS. It looks to me, Mr. Whitaker, what you are requiring here is not reporting of payments made. It is reporting of, and I notice you call it that in your statement, it is reporting of data that might or might not have some validity in pursuing someone for unpaid taxes. It could well put you on the trail of transactions wherein the doctor got no income at all, never was paid. I don't think it is uncommon for people to have insurance and when they get their insurance they don't have enough to pay everybody, or at least to pay everybody in full.

I think it is one thing to require individuals and businesses to report payments that they make. But to require another business, just because it may happen to be large, to report on transactions where they make no payments to the individuals involved, and have no legal way of finding out whether anybody else ever made the payments, that is what disturbs me.

I have a few other questions about this.

Mr. WHITAKER. May I make a comment? In answer to your last point, Senator Curtis. It certainly would be possible to gear up a system where, in this circumstance, the reporting would be limited to those charges or bills which the insurance company data showed actually were paid.

However, from the standpoint of minimizing the costs and burden on the insurance company itself, I feel that it is far easier not to require the insurance company to look over each bill and pull out only the amount paid. That is a proper function which I feel the Service can handle if it has the basic information.

Senator CURTIS. You referred a place or two in your statement about the costs to the insurance companies. What will it cost?

Mr. WHITAKER. We don't have any data from the insurance companies yet on this particular proposal. The report by the joint task force contains cost estimates submitted by the insurance industry but these estimates were on a somewhat different proposal. We feel we have materially lessened the costs.

We do not really have a way of pinpointing the cost ourselves. That is something which is peculiarly in the control of the insurance company.

Senator CURTIS. Whatever is the cost it will ultimately increase the cost of health insurance for all insured people, won't it?

Mr. WHITAKER. That is certainly a possibility, Senator Curtis, that is true.

Mr. WHITAKER. This, in essence, is a cost of the collection of tax dollars and it is a matter of governmental policy and congressional policy to determine who pays the cost. The costs have to be paid by someone.

Senator CURTIS. I don't mean to quibble over words but I would like to call your attention to a sentence on page 4 of your statement in the second paragraph, the last sentence. In there you are speaking of the defects in getting information. It says, "Chief among the defects, in our judgment, is the absence of a reporting requirement for unassigned payments for health care and services."

Well, actually, there have been no payments to the doctors, so far as the insurance company is concerned, isn't that correct?

Mr. WHITAKER. As I just pointed out, Senator, the insurance company does not monitor the actual payments to the doctor, that is true.

Senator CURTIS. It doesn't monitor it but you are asking for a law that makes them report it.

Mr. WHITAKER. What we are asking for is the amount which in the vast majority of cases will be paid by the insured or the insurance company, one or the other. While it may be true, in some instances, that bills may not be paid, certainly, in the vast majority of cases the doctors are paid for the services that they render.

Senator CURTIS. Did I understand your request would just deal with those cases where an insurance company had information of employment by the doctor amounting to more than $600 a year?

Mr. WHITAKER. No, Senator Curtis; we propose to have the $600 rule not apply at all. What we are proposing is that each bill that comes in with an unassigned claim be looked at and we are initially proposing that those bills under $100 be ignored for information reporting. When our proposal is fully effective, the insurance company will throw out bills under $25.

Senator CURTIS. I wonder if we have a problem here worth the inconvenience and burden and increase in health care insurance costs that is worth going after. Do you have any evidence of doctors failing to report income which comes from insurance companies?

Mr. WHITAKER. The best way I can answer you, Senator Curtis, is on the basis of our preliminary surveys of 11,000 tax returns of medical people that this Committee gave us last year.

Senator CURTIS. But that was all Government money, that was medicaid and medicare.

Mr. WHITAKER. That is correct.

Senator CURTIS. There is no insurance company involved in those.

Mr. WHITAKER. No; but we don't know that the doctors or the health care providers who furnished those services are any different from the vast majority.

Senator CURTIS. But the point is, I think, the Government can do anything they want to insofar as other Government agencies are concerned, without any legislation.

Mr. WHITAKER. Well, my point was simply this, Senator Curtis, that that is an indication that there is some serious underreporting generally. Other indications which the Service has had in the analyses of tax returns and voluntary compliance have generally indicated that the professionals are among the group who are guilty of underreporting or of nonreporting and among that group are the doctors. This is simply general results of analyses of information.

Senator CURTIS. Well, certainly you get some information in from the field, among the few doctors who are cheating on their income tax, are they cheating on payments in cash that are made when individuals call at the office to pay their bill or do you have a problem of cheating where the money originates with an insurance company?

Mr. WHITAKER. Well, again turning to these statistics, this analysis of these 11,000 tax returns, the indication there is that there is both. Certainly the medicare payments are not in the category of cash from a patient who walks in the door, and I think there is every reason to believe that the pattern which we found would be somewhat symptomatic of the entire group in the country.

Senator CURTIS. It is hard for me to believe medicare and medicaid people, so far as the Government is concerned, have any information that Internal Revenue can't get without a statute.

Mr. WHITAKER. But leaving aside, Senator Curtis——

Senator CURTIS. They can get all yours, and that is supposed to be confidential.

Mr. WHITAKER. There is a large gap between the private sector and the public sector. The medicaid payments are somewhat, I believe, less than half of the total health care costs of the country. Even assuming that we get all the information we need with respect to medicaid and medicare, that still leaves a large body of dollars that is not covered by information reporting.

Senator CURTIS. This Committee has certain oversight in connection with our tax collection laws, and the 11,000 horror cases referred to you were all medicaid and medicare, weren't they?

Mr. WHITAKER. Yes, sir.

Senator CURTIS. We haven't referred any others in that category. I am just disturbed, I realize you have a problem and I don't mean to be critical of people as individuals, certainly not. All of us want to see every taxpayer pay every dime that he owes because any that he escapes, somebody else has to pay it.

But by the same token, all taxpayers should be treated alike, and if we are going to require some people to report unassigned claims where the payment has not been made or maybe not at all made in that taxable year, I am wondering if it shouldn't be across the board.

This would be a new departure for this committee to give enforcing tools applied to one segment of our economy only. I don't think we

even do that in collecting taxes against gamblers. I think they have the benefit of the same reporting laws, or lack thereof, as any other taxpayers, and I have some very serious questions about requiring a report in order to trace data where there is no evidence that there has been a payment made. That is all, Mr. Chairman.

The CHAIRMAN. Senator Jordan.

Senator JORDAN. No questions.

The CHAIRMAN. Thank you very much, gentlemen, for your testimony, here today. You are excused.

The next witness will be Mr. Wilbur J. Schmidt, secretary, Department of Health and Social Services, Madison, Wis., and chairman of the National Council of State Public Welfare Administrators, in behalf of the American Public Welfare Association.

We are pleased to have you, Mr. Schmidt, and you may proceed, sir.

STATEMENT OF WILBUR J. SCHMIDT, SECRETARY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, MADISON, WIS., AND CHAIRMAN OF THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS, IN BEHALF OF AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. SCHMIDT. Thank you, Mr. Chairman and members of the committee.

As was stated, my name is Wilbur J. Schmidt. My position is secretary of the Wisconsin State Department of Health and Social Services. I had expected to be accompanied today by Mr. Bonin from your own State of Louisiana, and Mr. Swank from the State of Illinois, but their presence was required in their home States on account of important business necessary in connection with these matters and, hence, it was left to me to present the testimony.

The CHAIRMAN. I am sure they will be well represented by you, Mr. Schmidt.

Mr. SCHMIDT. Thank you.

I am appearing, of course, on behalf of the American Public Welfare Association in my capacity as chairman of the National Council of State Public Welfare Administrators.

While there are many features to H.R. 17550 to which we could appropriately address our attention, and many of which are very desirable, things like the improvement in social security benefits and automatic adjustments and some other things, we would like to use our time here today to emphasize our concern over one section of that bill which is section 225 known as the establishment of incentives for States to emphasize outpatient care under medicaid programs.

We have to do this because we are, very frankly, gentlemen, alarmed over what could be the result if this were to become law. This is the section, as I am sure you are aware, that increases the Federal share by 25 percent up to a total of 95 percent for outpatient and clinic services and for home health services. At the same time, it would reduce the Federal share by one-third for inpatient services in a general hospital or tuberculosis institution beyond 60 days of any calendar year, and it would also reduce the Federal share by one-third for inpatient care in a skilled nursing home beyond 90 days. For inpatient care in

Further, the Department of Health, Education, and Welfare states on pages 127 and 128 of the June committee report on H.R. 16311, and I quote from that:

> Health care problems for the new combined adult assistance program involve greater needs for long-term medical and custodial care and rehabilitation services—quite different in kind from the preventive and acute care of younger adults and children.

We believe, therefore, that these needs would not be adequately met if we were to entertain enactment of the provisions of section 225 of this bill.

The States are moving, as they can, in the direction of intermediate care facilities. But this is a slow process. They do not have full command over the provision of the services because they must rely in large measure upon the development of these under private or nonprofit auspices, and so as time is passing, while these kinds of facilities develop, States are forced to depend upon their services through their long-term care provisions of title XIX.

Now, what about the mentally ill, and the section in here which not only reduces the Federal participation of care for those individuals after the 90-day mark, but says nothing at all will be shared by the Federal Government after the next 275 days.

For the mentally ill, the complexity and uncertainty of needed treatment is reflected in the present State laws and programs. The State plan, under medicaid, has to show as well as see to it that assurance is given for immediate readmittance to a mental hospital upon the discovery that the patient is not being properly handled or his needs arise after release which call for his or her readmission.

It happens that among these who are over the age of 65, in particular, who are the ones in question here in the public mental hospital, that their conditioning—they may not show physical dependence, it is not subject to self-dependence necessarily at the end of the year's time and yet, at the same time, it cannot be said that they are no longer to be regarded in a patient status, although as far as this measure is concerned this would, in fact, be the end result.

Now, there is a statement on this subject that comes from the Health, Education, and Welfare Task Force on Medicaid, and I quote from that:

> We fully support the Department's commitment to modern concepts of care for the mentally ill and the development and implementation of alternatives to inpatient care in mental institutions, using title XIX funds where possible. Maximum effort should be encouraged in planning for alternate care, guided by the needs of the patient. In such a flexible approach to care, based on patients' needs, arbitrary limitation on duration of care of patients in mental institutions is inappropriate, and the task force recommends against imposition of any limitation.

So, we see, as we look through the whole matter that all that can really happen if we approach a solution of the problem of costs which, apparently, is underlying the introduction of this idea, through the process provided in section 225, will simply mean that the costs will be shifted to the States where the money is not available, and I would fear, gentlemen, that most likely the result of that would be that there would be a reduced level of care or level of benefits resulting therefrom, as I have already information that, and I am sure you have, too, to the effect that, some States had to reduce the levels of their

title XIX programs in the last couple of years for the lack of the State's share of the cost of this program.

I do not think we should overlook the fact that among the States having the most comprehensive title XIX programs we are also referring to States that are putting almost half of the total cost of this program in and so, therefore, have a very substantial stake as well as the Federal Government in the cost of continuing the title XIX effort.

Now, there is another section of the bill that we would like to support which deals with 90 percent reimbursement in order to encourage and bring about needed data processing systems.

There is no doubt that we have sporadic information available to us as to what really is happening to the people as recipients or as patients in this program, and what really is happening to the money.

There are many different kinds of data systems in the country dealing with this problem. There is no uniformity to it. States lack capacity in many instances to establish appropriate management systems for that purpose and, therefore, I think in order to have a more complete national overview, a better basis of planning and making decisions which affect national priorities and national investments that we certainly add a strong support to this provision.

Finally, in terms of my brief statement to you here this morning, I think that in the long run we believe that some better mechanism must be devised for financing and improving the delivery of the health care services for low-income individuals and families. One of its objectives should be to relieve the States from the present burden of financing, as I think we have reached a limit of that.

No constructive purpose would be served by setting up artificial incentives now or in the future to reduce the utilization of high cost long-term care facilities when genuine alternatives are not available.

The result of such a move, in our opinion, would be either a further increase in State costs or a reduction in needed services to people.

That completes the remarks I had in mind making, Mr. Chairman. I would be very happy to try to answer any questions you may have.

(The prepared statement of Mr. Schmidt follows:)

STATEMENT OF WILBUR J. SCHMIDT ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. Chairman and Members of the Committee. My name is Wilbur J. Schmidt. My position is Secretary of the Wisconsin State Department of Health and Social Services. I appear before you today on behalf of the American Public Welfare Association in my capacity as Chairman of the National Council of State Public Welfare Administrators.

Our primary purpose in appearing before your committee today is to express our serious concern with the proposal which is set forth in Section 225 of the H.R. 17550, "Establishment of Incentives for States to Emphasize Outpatient Care under Medicaid Programs." This section would increase the federal share by twenty-five percent up to a total of ninety-five percent for outpatient and clinic services and for home health services. At the same time it would reduce the federal share by one-third for inpatient services in a general hospital or tuberculosis institution beyond sixty days of any calendar year, and it would also reduce the federal share by one-third for inpatient care in a skilled nursing home beyond ninety days. For inpatient care in a hospital for mental disease, the federal share would be reduced by one-third beyond ninety days, and all federal participation would end after an additional two hundred and seventy-five days.

We want to make it clear that we support the purpose expressed by the President of placing special emphasis on outpatient health services, but we would sound a word of caution that the benefits from such a policy would not result in any material easing off in the need for long-term care in the immediate future. Underlying this proposal is the assumption that to reduce the federal percentage in institutional expenditures and to increase the federal share in outpatient care and home health services would result in a shift toward more appropriate and less costly care. We believe, however, that this assumption is not supportable. Incentives to reduce expenditures can only be effective when they apply to both parties—the provider, as well as the paying agency—and when acceptable alternatives are available.

Utilization and long-term care

Admission and length of stay in hospitals and nursing homes are determined by physicians, and the judgment that a patient can be cared for at home or in a less costly facility can only be made on a case-by-case basis. On the other hand, it is clear that there are already tremendous pressures on the state agencies administering Medicaid to hold down the costs. A very substantial proportion of all Medicaid recipients now live in states in which the state share of the cost is equal to the federal share, and therefore it might be presumed that the state incentive to reduce costs is equal to the federal incentive.

In the meantime, for a great many aged and other patients receiving long-term care, the practical alternatives to inpatient hospital and skilled nursing home care are limited. Moreover, the states are now in the situation of having moved to establish the existing programs in good faith at the urging of the federal government, and have entered into program and financial commitments on that basis. In the light of the present fiscal circumstances prevailing in most states, the reduction in the federal matching share would simply mean a curtailment of needed services. The urgent need for these services cannot be substantially reduced in the short term regardless of what incentives might be built into the federal matching formula, and the states are not able to pick up the added costs from their own resources.

The following comment in the recently published Report Of The HEW Task Force on Medicaid And Related Programs (page 114), brings into focus one of the dilemmas of the states in their efforts to reduce the utilization of long-term care: "Importantly, the Task Force thought that although classifying patients is sound, patients should not be summarily discharged from skilled nursing homes or other health facilities if alternate facilities are not available. Keeping a patient in a health facility when his needs for support services cannot be met elsewhere does not represent misuse; it represents a default on the part of the community to match services with needs. Investments in alternative services are the only humane way to solve the problem."

The Department of Health, Education and Welfare states on pages 127–8 of the June committee print of H.R. 16311: "Health care problems for the new combined adult assistance program involve greater needs for long-term medical and custodial care and rehabilitation services—quite different in kind from the preventive and acute-care of younger adults and children." We believe that these needs would not be adequately served under the provisions proposed in section 225 of the bill now before your committee.

Rates and costs

The states are already moving toward a greater utilization of intermediate care facilities when this type of care is indicated, and when the resources are available. We believe that the proposal to authorize the Secretary of HEW to establish, when necessary, a differential between matchable rates for skilled nursing homes and intermediate care facilities would be a reasonable and effective measure.

We are much more impressed with those provisions of the bill which would grant to the states greater discretions in determining the reasonableness of hospital costs and which would require the states to relate institutional reimbursement more closely to the Comprehensive Health Planning system.

Care of the mentally ill

For the mentally ill, the complexity and uncertainty of needed treatment is reflected in present state laws and program plans. A state plan for Medicaid must provide assurance of immediate readmittance to the institution when needed. In support of the new proposal, we are now told that necessary hospi-

talization for the mental patient 65 years of age or older rarely continues beyond one year, and that when these older patients are released from a mental hospital, they usually do not have physical illnesses requiring institutional care. These assumptions are not supported by the experience of the States.

Again we note with interest a passage from the above-mentioned Task Force Report: "We fully support the Department's commitment to modern concepts of care for the mentally ill and the development and implementation of alternatives to inpatient care in mental institutions, using Title XIX funds where possible. Maximum effort should be encouraged in planning for alternate care, guided by the needs of the patient. In such a flexible approach to care, based on patients' needs, an arbitrary limitation on duration of care of patients in mental institutions is inappropriate, and the Task Force recommends against imposition of any limitation."

Prevention and treatment

For these reasons, we must object to any action that would abruptly reduce the federal financial participation in the costs of long-term care under the Medicaid program. At the same time, we would express the hope that augmented resources for prevention and treatment will be made readily available for the enhancement of the lives of those who could benefit from these services.

Need for EDP systems

As administrators of the state Medicaid programs, we recognize the urgent need for assisting states with the costs of designing, developing, and installing mechanized claims processing an informational retrieval systems which would assure a higher degree of accountability and control. While some states have already made significant progress in this direction, we are confident that all states could benefit from additional federal assistance, both financial and technical.

We also favor those amendments which would tighten the Medicare program where policy and practice have tended to set many precedents for Medicaid, and believe that further efforts in this direction should continue.

CONCLUSION

In the long run, we believe that some better mechanism must be devised for financing and improving the delivery of health care services for low-income individuals and families. One of its objectives should be to relieve the states of the intolerable burdens of the present system. No constructive purpose would be served by setting up artificial incentives, now or in the future, to reduce the utilization of high-cost long-term care facilities when genuine alternatives are not available. The result of such a move would be either a further increase in state costs or a reduction in needed services.

The CHAIRMAN. Well, thank you.

Our big problem here, as I understand it, is that while some States have been doing a satisfactory job, there are other States where the program has been very wasteful and has not been properly administered. On the House side they thought, there should be some tightening up.

Let me just read you from the Comptroller General's Report on the Medicaid Program in California.

GAO's review revealed weaknesses in procedures and practices for approving and paying for nursing home care and other Medicaid programs in California. Also, no uniformity existed for making determinations on the necessity for nursing home care. On the basis of GAO's observations of approvals of nursing home care as studied in three counties in California, they concluded that a high percentage of patients in these three counties, 35 percent in one, 22 percent in the other, and 20 percent in the other were not in need of such care. GAO believes that Medicaid recipients received nursing home care without adequate determination that such care was warranted.

In addition, GAO found that in 22 of 260 cases examined, claims were paid for periods after a patient had died or had been discharged from the nursing home.

It is kind of ridiculous to pay nursing home claims for services supposedly rendered to a patient when the patient had died.

In 12 of 76 additional cases examined, nursing homes were receiving full payments under both Medicare and Medicaid programs for the same days of nursing home care.

Then, here is a situation in Maryland, and I quote:

Although the State agency had established criteria for control of admission of patients to nursing homes and subsequent eligibility redeterminations, the State agency and local health departments did not apply these criteria to patients admitted to nursing homes. As a result, we estimate that the State agency reimbursed nursing homes about $4.8 million for skilled services for recipients who did not require skilled nursing care and therefore were not eligible for Medicaid benefits.

Further, despite information obtained in a survey conducted by the State agency which showed 23 percent of all patients surveyed were receiving skilled care when less than skilled care was required, the State agency had not initiated corrective action. Also the State agency had not implemented procedures to assure that responsible State agency personnel or local health departments had complied with existing procedures and controls.

How would you feel about it if we amended section 225 so that it applies where States are not doing a good job or are not taking adequate care to control expenses, and that it does not apply where they are taking adequate steps to control expenses?

Mr. SCHMIDT. Mr. Chairman, I think that it is quite proper for the Federal Government to have a provision which can give it strong enough leverage to demand conformity to appropriate business practices here.

I do not know whether the way to do that is best through separation of those who do and those who do not by legislation. I think that there may be ways to do this through the processes which are well-known to the Federal Government through the audit route and other kinds of conformity leverages which they have.

I think that your effort to demand a higher level of efficiency in administration, therefore, could be met by something like that which may even be better and would not be part of section 225.

I think the thing that is wrong with 225 is that here we seek to cure problems of management through the very essence of Federal-State financial partnership, and I think this is the wrong way to obtain management effectiveness.

The CHAIRMAN. My thought is that if a State can give us reasonable assurance that patients in that nursing home after 90 days belong there, the State should continue to get the money. But if they cannot show us that, they should not continue to get the money. That is one way that we might try to solve it.

Anyway, I appreciate your concern; at the same time, I hope you appreciate our problems.

Mr. SCHMIDT. Yes.

The CHAIRMAN. Senator Curtis.

Senator CURTIS. Is it your recommendation that section 225 just be eliminated?

Mr. SCHMIDT. That is correct.

I would actually like one part of it, of course, but I cannot expect to have all the cream and everything. I would like to take the percent increase of Federal participation in the outpatient and then just scratch (b) and (c) of that section. That would——

Senator CURTIS. If you had to take it all or leave it all?

Mr. SCHMIDT. If I had to take it all or leave it all, if it is an all or nothing thing, now I have to speak for myself, of course, because my instruction from my body is to back the elimination of (b) and (c) and opt for the 25, but if I were to sit here and make my own commitment on this I would say I would rather have nothing than to be caught with this withdrawal of one-third of the money and the elimination of the final after 275 days of participation in the mental hospital care.

Senator CURTIS. My State of Nebraska is not a wealthy State. We have about 1.4 million people, and like every State, it is hard to get enough taxes to go around.

On May 26, 1970, the Honorable Norbertt Tiemann, Governor of Nebraska, wired me, and I placed in the record of these hearings on July 14 of this year, a telegram which stated:

> We estimate that the skilled nursing home section of the bill will cost the State of Nebraska an additional $1,500,000 per year. The section limiting funds for institutions for mentally defective will cost $1 million per year at the Beatrice State Home, and $500,000 per year for other mental institutions. The savings provisions in the bill for more Federal funding for outpatient care will result in only $45,000 per year savings in the State and county funds. Therefore, the net cost of the provisions of the bill will be $2,910,000 per year or $5,820,000 per biennium. The argument that these changes will decrease the unwarranted hospitalization is without merit.

Of course, that was the objective, but it is your opinion that it will not meet the objective.

Mr. SCHMIDT. Not immediately. I think there will be an improvement in the situation in the long term. I honestly have to believe that early attention to these health needs ought to have some effect or some influence on the later health of an individual. But this is not a dividend that is going to come the same day all the way around. It is going to take a long time to occur. So I would have to agree with the Governor.

Senator CURTIS. Is there any other way to bring it about?

Mr. SCHMIDT. I do not think so. We have a lot of sick people out there who——

Senator CURTIS. No, no; I mean you talk about some savings way down the road. Won't those come about anyway if we carry on the program right?

Mr. SCHMIDT. I think they will. I think that both levels of government will get their dividends at the same time when they do come about, not by force.

Senator CURTIS. Not by force of this.

Mr. SCHMIDT. That is right.

Senator CURTIS. But they will get it anyway.

Mr. SCHMIDT. Right. This is a typical picture. It is millions and millions, depending on the size of the State that it is going to be shifted, and it is going to hurt in the end because the legislatures will not have the money, and that will mean going around the medical assistance program and looking for ways to cut.

Another thing I would like to say about this: I think you gentlemen have a tremendous record in keeping faith with the commitments of the Federal Government in these longstanding grant-in-aid programs in this field. But here is one of the first examples where there would be a withdrawal by the Federal Government from a commitment it once made and upon which States have based the program planning

and program financing; that is to say, they are going to change the percentage on a deal that was previously made, and if this occurs it forever is going to be difficult, until we heal the wounds, to convince our legislatures that the Federal Government's percentages are real and that they will stand behind them, and this could be a very disastrous thing in some situations in trying to get good, stable program planning at the State level.

Senator CURTIS. When the Congress declines to enact a program to benefit individuals and States it may be a disappointment. But if it removes one that is already established it creates very serious problems.

Mr. SCHMIDT. Correct.

Senator CURTIS. And it may create problems that will result in a political reaction that causes the next Congress to overrule the cutback so the problem goes unsolved; isn't that right?

Mr. SCHMIDT. This is my opinion.

Senator CURTIS. That is all, Mr. Chairman.

The CHAIRMAN. Well, look, here is a report made by the General Accounting Office on an audit in Michigan.

They evaluated 378 clients in a skilled nursing home. They did it by strict interpretation of who required skilled nursing care and who did not. Only 22 percent of those people required skilled nursing care in that nursing home. Then when they used a more liberal definition and said it would include clients who required a large quantity of care in a skilled nursing home, not people who required skilled care but required large quantity of care of an unskilled nature, they could come up with an estimate that 58 percent, just a little more than half, could be justified as being in the skilled nursing home on the basis that they required a large quantity of care, even though they did not require skilled care.

Now, that is costing Michigan money just like it is costing us money, but why should they be there at all. I mean, the people who do not even require a lot of care, they do not require skilled care, and do not require a lot of it of any kind, why should we have them there, paying Federal and State money for them?

Mr. SCHMIDT. I think the answer probably is—and bear in mind, Mr. Chairman, I would not have the close-in insights to the Michigan thing—but I think it is probably like in my own State, and that is that until you get a plant which can be defined and described as an intermediate care facility, the physician, who is the one who has to state for continuing care in a nursing home, this is a requirement really in which he does not have any choice and, therefore, does have patients in these homes where you provide a quantity of care but not skilled in the sense of an around-the-clock nurse to be in attendance, and the reason this is difficult is that the public is not buying and erecting all these places, and an entrepreneur or the nonprofit sponsor has to make up his mind in which business he wants to operate, and if you have to imagine that some individual can, at the same time, be a skilled nursing home operator and an intermediate care facility provider, you get a situation that is almost impossible to deal with, and so you do not get the investment, and it is that—let me say further than that, if it is the quantity of care that is to be defined as the criterion for not needing skilled nursing home care and, therefore, it goes over to the intermediate care facility, the Federal Government participa-

tion in that is the same financially, and I do not see the force of the argument that that is unmanageable, when that is not actually going to accommodate the Federal fiscal problem anyway, and I think, therefore, the States have to be left to their own devices as to when they can get an establishment of intermediate care which is adequate to meet the need, and move away from what is called skilled nursing home care in the meantime.

You can take the cases off from the skilled nursing home rolls and have them in an intermediate care facility placement and come on with the same Federal financial participation, so you just move from one accounting record over to another, and the patient may still be in the same place.

You can go further than this. If it is personal care that the individual needs, it is one who cannot be completley self-dependent, you can even put him on cash assistance and draw the Federal financial participation and let him go buy room and board, in a sense. But we do not like to see these kinds of forced choices because sometimes this leaves the individual with less than the kind of care he ought to have.

The CHAIRMAN. Here is the problem. We were told that medicaid was supposed to cost $238 million a year more than the Kerr-Mills bill.

All right. Now, it is costing $3 billion a year. Next year it is estimated to cost about $6 billion, $3 billion Federal, $3 billion State. What on earth happened?

Well, in the first place, half these people were not supposed to be getting this care to begin with according to many audit reports.

So the House said, "Well, we had better just cut this thing off in some way. Our people over here say, if the State is doing a good job of cost control why shouldn't we continue to supply matching funds. But where by strict definition only 22 percent of patients belong in a skilled home to begin with, let us not supply matching in those situations.

If you people can show us a better answer, I would like to see it. I am not looking for any more problems. I am looking for answers at this stage of the game.

We obviously have something which is exceeding costs by a fantastic amount, and we feel as though we have been victimized. These people were not supposed to be charging for care for people who were dead.

Here are people who have been discharged and we are having to pay for them as though they are receiving care, we are being cheated left and right and, of course, I guess the State is being cheated along with the Federal Government. We want some way to bring this program under control and if you can show us a better way to do it, Mr. Schmidt, we would be glad to have your suggestions.

Mr. SCHMIDT. Mr. Chairman, first of all, I would like to say we would be favoring, and I think it would be the wish of the committee, we probably could make up a statement on this of what are regarded as adequate management rules in order to see that someone who is deceased is not paid. I mean, these are errors of fact which we can work at through administrative procedures, it seems to me, to protect.

I think we have to do that in all areas of business, and I certainly hope we are not paying dead people in the State of Wisconsin in homes that have burned down.

I can only say that programs operated by human beings for human beings, sometimes these things go through.

But when you come to the cost otherwise from that, we have had people in nursing homes in Wisconsin long before title XIX ever came across, and which were paid for by the other methods which, at the time, were largely State methods. We have not seen that we have just suddenly come on with a new crop, so to speak, just because of title XIX. We have got well over 30,000 licensed nursing home beds in the State and about 13,000 of them are occupied by title XIX, and the rest are being paid for in their own way.

So I think we have got a general inflationary effect in this. We have got a utilization and placement procedure which, I think, other States are following now as well, that calls for the combined judgment of the physician, the State nurse, and a social worker from the county welfare agency before placement is made in a nursing home and before a choice is made as to which one is able to do the job needed.

We have reviewed the patient's condition so he is not left there to linger when, perhaps, some other plan is enacted. But we have to, at the same time, face up to the fact that nursing home operators have increased costs, higher wages. This was traditionally a low-pay industry in years past, and it has now taken its place, along with other industries, at a recognized wage level at prevailing rates; it has to face the conditions of inflation and supply, and then the final thing in the whole area, and the reason why the program has gone so much beyond its expectation is we poured a lot of demand upon an already stretched health service industry, and this forced prices up.

I was just as shocked as were the administrators here in Washington when I had to appear before our legislature and tell them we were short of the mark by about 25 percent, too, and "We would just like to have about $9 or $10 million of your money because of that."

This does not go down very well.

Fortunately, this time around we are doing okay on our estimate. In fact, we are probably going to underrun a little bit, and that makes us all feel like we found some kind of answers.

I think these are the ways to do it. We have a Federal order of a 75-percentile control mechanism on physicians' fees, and we are not letting nursing homes increases go through unless it can be shown they come directly from cost accounting evidence, which means such things as wages and supplies.

We are not allowing increases in profits. So we are holding the line on them.

I think these are the ways to go at it. But I certainly do not think you can do it by reducing the Federal financial percentage.

The CHAIRMAN. Well, if you are doing a good job, I would think there ought not to be any reduction.

Thank you very much, Mr. Schmidt.

Mr. SCHMIDT. Yes, sir; I appreciate the opportunity Mr. Chairman.

The CHAIRMAN. Thank you.

We will now hear our next witness, who will be Mr. Henry H. Chase, coordinator of social legislation, in behalf of the Chamber of Commerce of the United States.

STATEMENT OF HENRY H. CHASE, CHAMBER OF COMMERCE OF THE UNITED STATES; ACCOMPANIED BY WILLIAM P. McHENRY, JR., ASSISTANT MANAGER, ECONOMIC SECURITY

Mr. CHASE. Mr. Chairman, as you have already indicated, my name is Henry Chase, and I am employed by the Humble Oil & Refining Co. in Houston Tex.

The gentleman with me today is Mr. William P. McHenry, Jr., of the national chamber's staff.

Since we will, of course, summarize our statement, we would like to have it entered in the record in full, if you please, sir.

The national chamber, on whose behalf I am speaking today, appreciates this opportunity to express its view on H.R. 17550 to this committee.

In brief, the chamber recommends that the Finance Committee approve the 5-percent benefit increase; reject the automatic benefit escalator; reject the automatic wage base escalator; maintain the $7,800 wage base; finance H.R. 17550 by increasing tax rates on employers and employees; increase the amount of exempt earnings; retain the existing workmen's compensation offset provision; approve those medicare proposals that will lower future costs.

Now, by the most widely accepted test of benefit adequacy, the benefit structure is satisfactory today. This situation prevails largely because Congress has acted to protect beneficiaries against inflation, and it did so by increasing benefits more than the amount actually needed to offset price changes.

Enactment of the proposed 5-percent benefit increase would become, in effect, an advance action by Congress to offset an anticipated price rise, and we support that action.

The bill provides for automatic benefit increases whenever the cost of living rises by 3 percent. Advocates of this escalator contend the Congress cannot be depended on to raise benefits as living costs rise. They also say a benefit escalator will depoliticize social security.

The Congress has held hearings on social security 15 times in the last 20 years. As a consequence, several benefit increases have been enacted which more than offset changes in the cost of living.

The CHAIRMAN. If I might just interrupt you at this point, it has been my experience since I have been here, that the easiest bill to pass is a simple across-the-board increase of benefits to offset inflation that has occurred since the last social security increase.

It is almost impossible for a Senator to explain why he did not vote for it.

Mr. CHASE. It is an awkward position to be in, I am sure.

Referring back to this action that you gentlemen of the Congress have taken in the past—and there is a table on page 5 that outlines the changes that have been made in benefits in relation to changes in the cost of living. Between December 1950 and January 1970, the cost of living rose by 51 percent, and Congress had increased benefits over that period by 83 percent.

Table 1 shows only the rise in cash benefits vis-a-vis changes in price levels.

The table does not indicate the value of the many other changes made in the program. One of the most important of these, of course,

was the enactment of medicare. HEW estimates that the value of the noncash medicare benefit is $38 a month.

When this value is added to the cash benefits it is evident that Congress has simply done much more than prevent aged beneficiaries from incurring a real loss in benefits over this period.

Even more significant than the record of Congress since 1950, is its performance since 1964. Since then Congress has raised benefits three times. Apparently another increase will be approved this year.

Recent Congresses certainly cannot be faulted for failing to raise benefits just because the cost of living has risen. There is no reasonable basis, we believe, for concluding that future Congresses will be less responsive.

Parenthetically, I would judge by your comment a moment ago, Senator, that this is not an unreasonable view of ours to anticipate that future Congresses will be equally responsive to changes in the cost of living.

It has been asserted that substituting mechanical devices for the judgment of Congress will remove the issue of the benefit increases, those designed to offset the impact of inflation, from politics. The House debate on H.R. 17550 clearly shows, however, that the issue of benefit adequacy will not be significantly depoliticized. The desirability of even limited depoliticization is questionable.

In the last analysis, neither social security nor any other major governmental program which affects practically everyone in this country should be removed from politics. To do so, simply would remove it from any influence or control by the electorate.

Now, if the cost-of-living escalator is incorporated in the social security program, it will inevitably spread to other public programs, private pension plans, and, conceivably, to the entire wage structure.

It is true that the Armed Forces and civil service retirement plans use cost-of-living escalators but those plans are comparable to private pension plans with the Federal Government standing as the employer.

It is indeed noteworthy, however, that those specialized and very limited plans are cited to support the contention that it is appropriate and desirable to adopt this same pattern in social security.

What better evidence could be submitted to indicate the almost certain consequences of incorporating a cost-of-living escalator in a program which has such broad effects as social security does. Indeed, in some respects it is difficult to visualize a more likely means of institutionalizing inflation, barring, of course, a flat mandate that the total wage structure in this country be predicated on a cost-of-living escalator.

We urge this committee to reject the automatic benefit escalator.

The proposed tax base escalator would authorize the Secretary of HEW to increase the amount of wages subject to tax biennially. Thus, the amount of social security taxes paid by many workers would be determined not by direct congressional action but by the Secretary of HEW.

A tax base escalator and benefit escalator, of course, are interrelated. The tax base escalator is intended to finance the costs that flow from the operation of the benefit escalator.

There is no assurance, however, that the revenue produced would be adequate to finance that benefit commitment. Inflation could advance

at a more rapid pace than taxable wages, in which case the benefit commitment could exceed the capacity of the tax base escalator to produce the necessary revenue.

Conversely, if inflation did not proceed at pace with the rise in taxable wages, excess trust funds would result. In either case, an ad hoc congressional examination and adjustment of taxes would be required to correct the imbalance. Obviously, there is no substitute for direct congressional control over the social security tax structure.

Now, if the tax escalator is adopted, the added costs resulting from an operation of the automatic benefit escalator will not be shared by all the workers and their employers. It will be paid for entirely by those workers who earn more than $9,000 a year.

The chamber considers it undesirable and inequitable to finance benefit increases solely through the increases in the taxable wage base.

The chamber is very concerned about shifting control over social security taxes from Congress to a Cabinet officer. Much of the public support for social security is based on the knowledge that Congress carefully weighs a proposed revision or increase in taxes that workers and employers must pay, and if future tax increases are effected without such congressional review, the confidence of both workers and employers in the program may be adversely affected.

Whether or not taxpayers agree with the Congress in every case, one thing is clear: I think greater reliance is placed on the considered action of responsible men than upon results produced by mechanical contrivances. Accordingly, we urge you to reject the tax base escalator.

Now, the 5 percent benefit increase and the other costs in H.R. 17550 will be financed by raising the taxable wage base to $9,000 next year. OASDI and Medicare tax rates, higher than those projected in the present law, would not become effective until 1980.

Under present law, the maximum present social security tax, that is both OASDI and medical insurance, will rise to $406 next year, to $441 in 1975, to $452 in 1980, and ultimately to $460, assuming no change in the statute.

Under H.R. 17550, the maximum tax would be $468 next year. Due to the automatic tax base escalator, it is estimated to be $612 in 1975, $780 in 1980, just 10 years away, and eventually to $1,365.

The chamber recommends that the costs of this bill be financed by increasing social security tax rates on as current a basis as practicable.

Mr. Chairman, in conclusion, there are three points we would like to emphasize. The 5-percent benefit increase should be enacted.

The $7,800 wage base should be retained.

But the National Chamber is strongly opposed to the automatic benefit and wage base escalators.

We sincerely urge this committee to reject those proposals.

Mr. Chairman, that concludes my statement, and I thank you.

(The prepared statement of Mr. Chase follows. Hearing continues on page 827.)

Statement of the Chamber of Commerce of the United States by Henry H. Chase

My name is Henry H. Chase. I am employed by the Humble Oil and Refining Company, Houston, Texas. For several years, I have served on the National Chamber's Committees concerned with Social Security and Unemployment Compensation matters.

The gentleman on my left is William P. McHenry, Jr., Assistant Manager, Economic Security, of the National Chamber's staff.

Today, I am speaking on behalf of the National Chamber, the world's largest federation of business enterprises and organizations. Its membership embraces 39,000 business enterprises, 3,800 trade and professional associations, and local and state chambers of commerce, with an underlying membership of approximately 5 million individuals and firms.

SUMMARY OF THE NATIONAL CHAMBER'S POSITION

The National Chamber appreciates this opportunity to express the views of business on H.R. 17550, a proposal that would make fundamental changes in Social Security and in Medicare. After careful review and evaluation of this bill, the Chamber recommends that the Finance Committee:

1. Approve the 5 per cent benefit increase;
2. Reject the automatic escalators related to benefits and the retirement test;
3. Reject the automatic wage base escalator;
4. Maintain the taxable wage base at its present level of $7800;
5. Finance the 5 per cent benefit increase, and the remaining costs of H.R. 17550, by increasing tax rates on both workers and employers;
6. Increase the annual amount of "exempt" job earnings under the retirement test from $1680 to $2000;
7. Maintain the disability "offset" provision which allows a beneficiary to receive concurrent payments from Social Security and Workmen's Compensation equal to 80 per cent of prior earnings;
8. Approve those proposed changes in the Medicare program that are intended to lower or restrain future costs.

ACROSS-THE-BOARD BENEFIT INCREASE

For many years, the National Chamber has supported the concept that Congress should periodically examine all aspects of Social Security, including benefit levels, to determine whether adjustments in the program are needed. It is apparent that, from time to time, changes in benefit amounts are required to assure that the great majority of elderly beneficiaries are not compelled to seek Old-Age Assistance for their ordinary expenses of living.

A guideline, enunciated by the House Ways and Means Committee, states: "The protection afforded by the program may be considered adequate only when benefits are high enough, when added to savings and assets normally accumulated, so most beneficiaries will not have to apply for public assistance for the ordinary expenses of living." [1]

The first Commissioner of Social Security, Dr. Arthur J. Altmeyer, asserted that the benefit structure, on the whole, would be satisfactory if the vast majority of beneficiaries—at least 90 per cent—did not have to seek public relief to supplement their Social Security benefits.[2] In other words, if no more than 10 per cent of the old-age beneficiaries were receiving Old-Age Assistance, the benefit structure should be considered adequate to achieve the basic objective of this social program. By this test, the benefit structure is satisfactory today. The proportion of aged Social Security beneficiaries who also receive Old-Age Assistance to supplement their benefits has fallen from 12.6 per cent in September 1950 to 7.4 per cent in February 1970.[3]

In large part, this situation prevails because Congress has given regularly recurring study to the Social Security program and has acted to protect beneficiaries against the effects of inflation by increasing benefits more than the amount actually needed to offset rising prices. Thus, the 5 per cent benefit increase provided for in H.R. 17550 is, in effect, an advance action by Congress to offset an anticipated rise in the cost of living.

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[1] See, *Social Security Amendments of 1954*, House Report No. 1698, 83rd Cong., Second Session, p. 2.

[2] See, Hearings, *Social Security Act Amendments of 1949*, House Ways and Means Committee, 81st Cong., Second Session, pp. 1089 and 1220.

[3] See, U.S. Department of Health Education and Welfare, *Concurrent Receipt of Public Assistance Money Payments and Old-Age, Survivors, and Disability Insurance Cash Benefits by Persons 65 and Over*, NCSS Report G-2, Table 1, February, 1970.

This, of course, is not the first time that Congress has taken advance action on a benefit increase. For example, in 1969 and in 1967, Congress anticipated economic conditions and approved increases sufficient, not only to maintain the purchasing power of benefits, but also to provide a margin of safety against subsequent price increases. Such action is desirable at this time also, and is consistent with past Congressional practice. To assure that the benefit structure continues to be properly maintained during this period of rising prices so that the burden of inflation does not fall with disproportionate weight on retired workers and other Social Security beneficiaries, the Chamber recommends that the proposed 5 per cent benefit increase be enacted.

THE AUTOMATIC BENEFIT ESCALATOR

Section 103 of H.R. 17550 calls for the automatic adjustment of benefits. In the future, benefits would be increased whenever the cost of living, as measured by the Consumer Price Index, rose by at least 3 per cent. Under this arrangement, the monthly average of the Consumer Price Index (CPI) for the third calendar quarter of 1972 would be compared with the monthly average of the CPI for the third quarter of 1971. If, for example, the monthly average of prices rose by 3 per cent or more between 1971 and 1972, then benefits would be increased by a corresponding number of percentage points. The first year benefits could be increased under this provision is in 1973.

The bill does not include a provision to reduce benefits if the cost of living decreases in the future.

The advocates of an automatic benefit escalator contend that this provision is needed because:

It is uncertain that Congress will act to improve benefits when such action is needed because of a rise in the cost of living;

A benefit escalator will "depoliticize" this aspect of the Social Security program.

Evaluating Congressional Performance

Congress has examined the need and desirability of effecting changes in the Social Security program 15 times during the past 20 years. Several across-the-board benefit increases were made during that period; these more than offset the change in the cost of living. Table I, on the following page, demonstrates this point. Between December 1950 and January 1970, the cost of living rose by 51 per cent, and Congress increased benefits by 83 per cent.

TABLE I.—INCREASE IN THE COST OF LIVING COMPARED WITH BENEFIT INCREASES APPROVED BY CONGRESS, DECEMBER 1950–JANUARY 1970[1]

Month and year	Consumer price index[2] (1957-59=100)	Average monthly price increase (percent)	Average monthly benefit, workers who retired in 1950	Cumulative benefit increase (percent)
December 1950	87.1		$49.50	
September 1952	93.0	6.8	55.70	12.5
September 1954	93.5	7.3	60.70	22.6
January 1959	100.9	15.8	65.00	31.3
January 1965	108.9	25.0	69.60	40.6
February 1968	118.6	36.2	78.70	59.0
January 1970	131.8	51.3	90.60	83.0

[1] Data on average monthly benefits payable from 1950 to 1968 obtained from U.S. Department of HEW, Social Security Bulletin, Annual Statistical Supplement, 1968 (table 13, p. 31). Data for 1970 obtained from House Ways and Means Committee, Social Security Amendments of 1969, Rept. 91-700, 91st Cong. 1st sess. p. 16.

[2] Data from Bureau of Labor Statistics.

Note: Since 1950, Congress has enacted 6 general benefit increases: 12.5 percent under the 1952 amendments (effective in September 1952); 9 percent under the 1954 amendments (effective in September 1954); 7.1 percent under the 1958 amendments (effective in January 1959); 7.1 percent under the 1965 amendments (effective in January 1965); 13.1 percent under the 1967 amendments (effective in February 1968); and 15.1 percent under the 1969 amendments (effective January 1970 but payable in April).

It should be noted that Table I relates only to the rise in benefit levels vis-a-vis changes in the Consumer Price Index. It does not indicate the value of the many other changes made in the Social Security program by Congress during that 20-year interval. One of the most important changes, when measured by the

dollar value to the elderly, was the enactment of Medicare. The Department of Health, Education and Welfare has estimated that the value of the non-cash benefits available under the Medicare program is about $38 per month. When this benefit value is added to cash benefits, as it certainly should be, it is evident that Congress has done more than merely prevent aged beneficiaries from incurring any real loss in their aggregate benefit entitlement.

Perhaps even more significant than the action of Congress over the last 20-year period is its performance since 1964. In the last five years Congress has raised benefits on three occasions. And, as these hearings indicate, there is every reason to expect that another across-the-board increase will be approved this year.

Whatever may have been the case in the comparatively distant past, recent Congresses have been prompt to act to assure that benefits are not watered down as a consequence of the inflation to which the entire nation has been subjected. There is no valid basis for concluding that future Congresses will be less responsive to upward movement in the cost of living.

Removing Social Security from Politics

It has been asserted that substituting mechanical devices (i.e., benefit and wage base escalators) for the considered judgment of Congress would remove the issue of benefit increases designed to offset the effects of inflation from politics. The assertion gives rise to two questions:

1. Would such "depoliticization" actually occur?
2. Would "depoliticization" be desirable?

The House debates on H.R. 17550 clearly indicated that the broad issue of benefit adequacy would not be "depoliticized". Those who supported the escalator provision stated flatly that the escalator would not, and should not, preclude the need for further Congressional review of benefit levels. At most, therefore, the "depoliticization" would be of a limited nature.

The desirability of even limited "depoliticization" is subject to question. Would it be in the best interests of Socal Security beneficiaries and the taxpayers who support the program? In a program as significant as Social Security, it is essential that the judgment of Congress be brought into play whenever changes or revisions are contemplated. In the final analysis, neither Social Security nor any other major governmental program which affects virtually the entire populace can be, or should be, removed from "politics", since to do so would remove it from any influence or control by the electorate.

Inflationary Potential

An automatic escalator could, and almost certainly would, have wide ramifications. If this principle is established in Social Security, it inevitably will spread to other public programs such as Public Assistance, Unemployment Compensation, Workmen's Compensation, state and local retirement systems; to private pension and retirement programs; to negotiated wage agreements; and, conceivably, to the entire wage structure.

Although it is true that the Armed Forces and Civil Service retirement plans utilize cost of living escalators, those programs are in the nature of private pension plans with the federal government standing as the employer. Accordingly, the use of escalators in those programs has not had the wide ramifications that would flow from the incorporation of that principle into Social Security. It is noteworthy, however, that those two specialized and limited programs are cited to support the contention that it is reasonable and appropriate and desirable to follow the same pattern in Social Security. No better evidence could be cited to indicate the almost certain consequence of incorporating a benefit escalator in a program which has the broad effects Social Security does. Indeed, it is difficult to visualize a more rapid means of institutionalizing inflation—barring a mandate that the total wage structure in this country be predicated on a cost of living escalator. (It is interesting to note that legislaion now pending in the House would tie the federal minimum wage to a cost of living escalator.)

We urge this Committee to reject an automatic benefit escalator for Social Security because it is unnecessary and unsound, and because it would have widespread adverse effects on other governmental and private programs.

THE AUTOMATIC WAGE BASE ESCALATOR

The Secretary of Health, Education and Welfare would be authorized to increase the amount of wages taxed—and thus the amount of the Social Security tax—every two years. Those automatic increases would be based on the Secre-

tary's determination of the extent to which average taxable wages of workers covered by Social Security have risen since 1971. Under this formula, the estimated taxable wage base would be $9,600 in 1973, $10,200 in 1975, $11,400 in 1977, $12,000 in 1979, $13,200 in 1981—and, eventually, $21,000 by 993.

The automatic wage base escalator is unacceptable to the National Chamber. Adoption of this proposal would mean that the amount of Social Security taxes paid by some workers would be increased, not as a consequence of direct Congressional action, but by action of the Secretary of Health, Education and Welfare.

The wage base escalator is intended to finance those benefit costs that result from the operation of the benefit escalator; however, there is no assurance that the added revenue produced would be adequate to finance that benefit commitment. It is possible, for example, that inflation may advance at a more rapid pace than taxable wages. Thus, the benefit promises could exceed the capacity of the wage base escalator to produce the required revenue. Conversely, if inflation did not proceed apace with the rise in taxable wages, an excessive trust fund balance would result. In either case, an ad hoc Congressional examination and adjustment of taxes would be required to correct the imbalance. Obviously, there is no substitute for direct Congressional control over the Social Security tax structure.

If the wage base escalator were to be adopted, it would mean that the added costs resulting from the operation of the automatic benefit escalator would not be shared by all workers and their employers. Rather, it would be financed entirely by loading the added tax burden on those workers who earn more than $9000 a year. This would be the first time in the history of Social Security that Congress financed a benefit change entirely through a wage base increase. On all previous occasions when Congress has raised benefits, or made other program changes, the added costs have been financed either by an increase in tax rates on all workers and their employers or by a combination tax rate and wage base increase.

The National Chamber considers it undesirable and inequitable to finance such benefit increases solely through increases in the taxable wage base.

The Chamber is very concerned about shifting control over Socal Security taxes from the Congress to a Cabinet officer. Much of the public support for the Social Security program is based on a belief that the Congress carefully considers proposals to revise or increase the taxes that workers and employers must pay. If future tax increases are to be effected without Congressional review, the confidence of both workers and employers in the program may be adversely affected. Whether taxpayers agree in every instance with the changes made by Congress, the fact remains that greater reliance is placed on the considered and careful action of responsible men than upon results produced by mechanical contrivances. We urge you to delete the wage base escalator from the bill.

FINANCING CASH BENEFIT CHANGES

H.R. 17550 would finance the 5 percent benefit increase and the other costs in the bill by raising the taxable wage base from $7800 to $9000 in 1971. In addition, tax rates higher than those projected under present law would become effective in 1980.

Table II compares Social Security and Medicare taxes under present law and under H.R. 17550 for an employee paying the maximum tax. Under present law, the maximum tax is scheduled to rise from $374 this year to $406 next year and, eventually, to $460. On the other hand, under H.R. 17550, the maximum tax will rise to $468 in 1971 and to much larger amounts in the future as a result of the automatic wage base escalator. It is estimated that the maximum employee tax will be $780 in 1980, $975 in 1985 and eventually $1365.

When Congress raised the taxable wage base to $7800 in 1968, it was $1,000 above the median earnings of regularly employed male workers. Today it is estimated that the existing wage base is still $400 above the median earnings of regularly employed male workers.

Median earnings of regularly employed male workers is a reasonable yardstick to use when considering whether or not a wage base change is necessary. This guideline will insure that half of all regularly employed male workers have their total earnings protected against job income loss. At the same time, this would allow the other half of the workers, who have some earnings not taxed, to use a greater proportion of their earnings to save or spend as they choose.

As Table III shows, 1972 would probably be the earliest time for Congress to consider any change in the wage base for tax or benefit purposes. Any consideration of a further increase in the wage base should be referred until that time.

TABLE II.—SOCIAL SECURITY AND MEDICARE TAXES—PRESENT LAW COMPARED WITH HOUSE SOCIAL SECURITY BILL (H.R. 17550)

Year	Tax rates[1]		Taxable wage base		Maximum employee tax[2]	
	Present law (percent)	H.R. 17550 (percent)	Present law	H.R. 17550	Present law	H.R. 17550
1970	4.8	4.8	$7,800	$7,800	$374.40	$374.40
1971-72	5.2	5.2	7,800	9,000	405.60	468.00
1973-74	5.65	5.2	7,800	[3] 9,600	440.70	499.20
1975	5.65	6.0	7,800	10,200	440.70	612.00
1976	5.7	6.0	7,800	10,200	444.60	612.00
1977	5.7	6.0	7,800	11,400	444.60	684.00
1979	5.7	6.0	7,800	12,000	444.60	720.00
1980	5.8	6.5	7,800	12,000	452.40	780.00
1981	5.8	6.5	7,800	13,200	452.40	858.00
1983	5.8	6.5	7,800	14,400	452.40	936.00
1985	5.8	6.5	7,800	15,000	452.40	975.00
1987	5.9	6.5	7,800	16,800	460.20	1,092.00
1989	5.9	6.5	7,800	18,000	460.20	1,170.00
1991	5.9	6.5	7,800	19,200	460.20	1,248.00
1993	5.9	6.5	7,800	21,000	460.20	1,365.00

[1] Tax rates for both social security and medicare.
[2] Employer must match employee tax.
[3] H.R. 17550 calls for initial increase in the taxable wage base from $7,800 to $9,000 in 1971. All subsequent increases, beginning with 1973, will be made in accordance with a formula based on estimated increases in average taxable wages. The Secretary of HEW, not the Congress, will determine low much to raise the taxable wage base, Figures for taxable wage base from 1973 on, obtained from Office of the Actuary, Social Security Administration.

TABLE III.—COMPARISON OF SOCIAL SECURITY TAXABLE WAGE BASE WITH MEDIAN ANNUAL EARNINGS OF REGULARLY EMPLOYED WORKERS 1960-75[1]

Year	Taxable wage base	Median annual earnings		Year	Taxable wage base	Median annual earnings	
		Men	Women			Men	Women
1960	$4,800	$4,837	$2,706	1968	$7,800	$6,800	$3,770
1961	4,800	4,950	2,776	1969[2]	7,800	7,100	3,930
1962	4,800	5,139	2,876	1970	7,800	7,400	4,100
1963	4,800	5,298	2,956	1971	[3] 9,000	7,700	4,270
1964	4,800	5,629	3,063	1972	9,000	8,050	4,440
1965	4,800	5,739	3,168	1973	9,600	8,400	4,630
1966	6,600	6,124	3,338	1974	9,600	8,750	4,830
1967	6,600	6,360	3,510	1975	10,200	9,130	5,030

[1] Data for 1960-68 obtained from U.S. Department of Health, Education and Welfare, Social Security Bulletin, Annual Statistical Supplement, 1968, table 36, p. 52 "Regularly Employed Workers" refers to 4-quarter wage and salary workers covered by Social Security.
[2] Growth in median annual earnings estimated from 1969 through 1975. Projected annual increase based on experience from 1960 through 1968.
[3] H.R. 17550 calls for an initial increase in the taxable wage base from $7,800 to $9,000 effective in 1971. All subsequent increases, beginning in 1973, will be made in accordance with estimated increases, as determined by the Secretary of H.E.W., in average taxable wages of workers covered by Social Security.

We recommend that the Social Security program be kept on a self-supporting basis by financing the 5 percent benefit increase, and the remaining costs contained in the bill, by increasing Social Security tax rates on as current a basis as practicable. Because the benefit increases are broadly distributed, all covered workers and their employers should bear a share of the added cost burden. This result can be achieved only by increasing tax rates.

MODIFICATIONS IN THE RETIREMENT TEST

Social Security benefits are intended to provide a partial replacement of a worker's job income loss when he is compelled to withdraw from the labor market because of age, total and permanent disability, or death. The so-called "retirement test" is the basis for determining whether a beneficiary has substantially retired from the labor force or is continuing to support himself by working.

Under present law, a beneficiary can earn $1680 a year—$140 a month—and still receive all his benefits; these are called "exempt" earnings. For earnings between $1,680 and $2,880, one dollar in benefits is withheld for every two dollars of earnings. If a worker makes more than $2,880, one dollar in benefits is withheld for each dollar of earnings.

H.R. 17550 would make three changes in present law:

1. The annual amount of "exempt" earnings would be increased from $1,680 to $2,000 effective in 1971.
2. For earnings in excess of $2,000 per year, one dollar of benefits would be withheld for every two dollars of earned income.
3. The annual amount of "exempt" earnings would be automatically raised in the future as average taxable wages rise.

The National Chamber supports the increase in the annual amount of "exempt" earnings from $1,680 to $2,000 because this change would help encourage part-time work among the relatively few elderly persons who are affected by this condition of eligibility.

The Chamber recommends that for earnings in excess of $2,000 and up to $3,200, benefits be reduced one dollar for each two dollars of earnings and, for earnings in excess of $3,200, benefits be reduced by one dollar for each dollar of earned income. This recommendation parallels the present provisons in the law and reflects the studied opinion of the Ways and Means Committee as expressed in the bill it reported to the Floor of the House. In support of the action we recommend, the Finance Committee's attention is directed to a study made by the Social Security Admnistration on the effects of the retirement test. This study pointed out that:

"Analysis of the effect of the retirement test on older people indicates that 90 percent of the people eligible for benefits are probably not affected by the test because they are 72 or older or are unable or unwilling to work to any substantial degree. Thus, any change in the test, including its elimination, would not help at all the vast majority of people who are eligible for benefits; the people who would benefit from elimination or liberalization of the retirement test would be those who continue working and earning relatively substantial incomes." [4]

The chamber is opposed to the automatic upward adjustment of the "exempt" earnings amount under the escalator provisions set out in H.R. 17550. Revision of any element of the Social Security program should be made only after Congress has evaluated the advisability of such change at the time the change is being considered and in the light of the conditions that then exist.

WORKMEN'S COMPENSATION

Existing law limits the amount of disability benefits an individual can receive concurrently under a Workmen's Compensation program and under the disability benefit provisions of the Social Security Act to 80 percent of the individual's prior average wage. H.R. 17550 would remove this limitation and an individual would be permitted to receive concurrent payments equal to 100 percent of his prior average wage.

One of the main objectives sought by the government, by Workmen's Compensation insurers, and by employers, when a person has incurred a permanent and total disability, is rehabilitation of the worker. Once the need for immediate medical care has been met, attention turns to efforts to rehabilitate the individual in the hope that he can and will again become self-reliant and self-sufficient. The disabled person must be motivated to undertake the often long and arduous task involved in rehabilitation. Experience shows that in the absence of motivation, little if any progress can be achieved.

An economic incentive also aids in the process of rehabilitation according to those who have had extensive experience in this field. Workmen's Compensation insurers are fearful that a reduction in the "offset" may have an adverse effect on work incentives of disabled workers. To the extent that a worker receives combined benefits in excess of preinjury pay, an incentive toward rehabilitation has been withdrawn. As the Finance Committee pointed out in 1965, ". . . it is desirable as a matter of sound principle to prevent the payment of excessive combined benefits." [5]

Spokesmen for the Administration urged the Finance Committee on July 14 not to "go along with the House provision" because it is complicated and merits further study. The Administration recommended that the Social Security Advisory Council study this issue.[6]

The National Chamber recommends that the present provision of the law be continued in effect.

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[4] See, U.S. Department of Health, Education, and Welfare, "The Retirement Test under Social Security," report on a study called for by the Congress in Public Law 90-248 (the Social Security Amendments of 1967), January 9, 1969, p. 9.

[5] See, *Social Security Amendments of 1965*, Report 404, 89th Cong., 1st Sess., p. 100.

[6] See, Colloquy between Senator Talmade and Robert M. Ball, Commissioner, Social Security Administration, hearings on H.R. 17550.

THE RISING COSTS OF MEDICARE

The latest cost estimates for Medicare (Hospital Insurance) show that the program is in serious financial difficulty. Information submitted to the Subcommittee on Medicare and Medicaid by the former Chief Actuary reveals that benefit outgo will exceed "tax take" by a substantial margin. Without additional financing, the Hospital Insurance Trust Fund will be exhausted in 1972.[7]

The Senate Finance Committee, but more especially the Subcommittee on Medicare and Medicaid, are to be commended for undertaking the comprehensive investigation which has uncovered the serious deficiences in the operation and administration of the present program. Many of the corrective actions in the House bill reflect the work of the Subcommittee and its staff. The National Chamber wholeheartedly concurs with the Finance Committee's objective of making this program function on a more effective and economical basis.

Correcting the Deficit

H.R. 17550 proposes to solve the immediate need for additional revenue for the Medicare program by raising both the tax rate and the taxable wage base. The Medicare tax rate would be increased from 0.6 percent to 1.0 percent on each employee and employer effective in January 1971. The taxable wage base would be increased from $7,800 to $9,000 next year also. Moreover, in the future, additional tax money would be channeled into the Medicare program on a *continuing* basis via *automatic* increases in the taxable wage base beginning in 1973.

The first four years' experience with Medicare confirms our earlier conviction that it is virtually impossible to develop reliable long-range cost estimates for a program that pays for services. However, the facts show that the Medicare (Hospital Insurance) program must have additional financing immediately if it is going to meet its commitments. The National Chamber is opposed to any increase in the taxable wage base, automatic or otherwise, to accomplish this objective. Instead, we recommend that Congress raise Medicare tax rates to provide an immediate solution to the revenue problem.

There are a number of proposals in the House bill which are intended to lower or restrain the future costs of the Hospital Insurance and Supplementary Medical Insurance programs. The National Chamber will confine its comments to the most significant provisions.

Health Maintenance Organization Option

Under this proposal, Medicare beneficiaries who live in an area served by a Health Maintenance Organization would have the option of receiving their services under this arrangement rather than from individual hospitals and doctors. Qualified organizations would receive a fixed rate of payment for each beneficiary, determined in advance for each firm on an annual basis. The fixed rate would be somewhat less than Medicare now pays for comparable treatment. As we understand it, the payment is to be no more than 95 percent of the estimated amount that would be payable if such coverage services were furnished outside the framework of a Health Maintenance Organization.

There is no evidence in the Ways and Means Committee report indicating that the Health Maintenance Organization option would result in lower program costs. According to the Social Security Chief Actuary:

"No valid experience under the Medicare program is available for the purpose of making any cost estimates of the effect of this provision. To the extent that adequate actuarial analysis can be made in the future as to the actual operation of these Health Maintenance Organizations, there could be a significant reduction in the long-run cost of the Medicare program. . . . In the early years of operation, however, there migth be sligthly increased program costs, because the relatively few organizations of this type in existence are being reimbursed only their actual costs, whereas under the provisions of your Committee's bill, they would, in the future, be reimbursed somewhat more than costs. . . ."[8]

Accordingly, it would be unsound to implement this feature without studying its implications more carefully. We recommend that the Health Maintenance

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[7] The Social Security Chief Actuary, Mr. Robert J. Myers, submitted two cost estimates to the Finance Committee. Under the first, which assumes a $7800 taxable wage base, the deficit is $216 billion. The second estimate, which assumes that the tax base will be raised from time to time to keep up to the general earnings level, shows a deficit of $94 billion. See, Hearings, *Medicare and Medicaid,* Senate Finance Committee, 91st Cong., 2nd Sess., Part 1, p. 33.

[8] See, House Ways and Means Committee, *Social Security Amendments of 1970*, Report 91–1096, 91st Cong., 2nd Sess., p. 84.

Organization option be handled entirely on an experimental basis so that Congress will not be "locked in" if experience demonstrates that this approach has no real value.

Limitations of Physician Fee Increases

Under this provision of the Ways and Means Committee bill, allowable fees recognized for Medicare payment would be limited either to presently recognized charges—or to a new prevailing level set at the 75th percentile of customary charges for a given service in an area during calendar year 1969. In the future, reimbursible charges would move up in proportion to increases in an economic index which would take into account rises in the cost of living and in the cost of operating a physician's office.

According to the Social Security Chief Actuary, the limitations on prevailing charge levels are estimated to reduce costs by about one to two percent in the first year, or by $20 to $40 million in fiscal year 1971.

The National Chamber endorses efforts to control program costs. However, it would oppose as a form of price control any attempt to "fix" physician's fees.

Other Proposals

There are six other provisions in the Ways and Means Committee bill which the National Chamber supports because they may result in cost savings to the program or improve operating effectiveness. The National Chamber recommends that the Finance Committee approve these provisions without change:

1. A limitation on the use of federal funds for capital expenditures;
2. Experiments in prospective reimbursement;
3. Limits on provider costs recognized as reasonable;
4. Termination of payments to suppliers who abuse the program;
5. Government payment no higher than charges; and,
6. Institutional planning and budgeting.

CONCLUSION

In conclusion, we want to emphasize the following points:

The National Chamber recommends that the 5 percent across-the-board benefit increase be enacted.

We recommend that the $7,800 wage base be retained.

The National Chamber is strongly opposed to the automatic benefit and wage base escalators, and urges this Committee to reject those proposals.

The CHAIRMAN. Thank you very much, sir, for your statement.

I was going to recess for noon, but Mr. William R. Hutton has to take a plane this afternoon, and he asked to be recognized briefly.

Is Mr. Hutton here?

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS; ACCOMPANIED BY RUDOLPH T. DANSTEDT, ASSISTANT TO THE PRESIDENT

Mr. HUTTON. Thank you for your courtesy, Mr. Chairman. I do have to make a plane to go to Chicago this afternoon.

I am appearing for the National Council of Senior Citizens, which is a 2½-member organization. Since I will speak very briefly, I would like to have included my full statement and the testimony of the president of the national council, Nelson H. Cruikshank, who, I know, is well-known to you, sir, and other members of the committee. He is called away to Japan to an international meeting, but had prepared this testimony in the expectation that he would be able to appear personally.

The CHAIRMAN. He is a very persuasive spokesman, and we will certainly receive it.

Mr. HUTTON. I would also like to say I am accompanied by Mr. Rudy Danstedt, who is the assistant to the president of the national council.

My statement, which I have asked to be introduced for the record, deals with a matter of great concern to the Council of Senior Citizens. This is the serious situation which has arisen concerning the licensing of nursing home administrators set up by the States in accordance with section 1908 of the Social Security Act as enacted in the 1967 amendments.

Now, the intent of this section 1908 amendment was clearly to safeguard the health and safety and welfare of nearly 2 million patients in nursing homes through the licensing of competent administrators.

These licensing boards are charged with all kinds of developing, imposing, enforcement of standards, and are further charged with applying appropriate techniques for determining whether any particular administrator meets that standard.

But early this year, the National Council learned from various States of our groups in the States that these licensing boards which were being set up were being dominated by the nursing home administrators requiring licenses.

Sir, the details of this control of boards by administrators is described in the communications, which we have had with the Department of Health, Education, and Welfare, and are included in my full statement.

These reveal that right at the moment some 60 percent of the licensing boards of nursing home administrators throughout the country are in the position of being dominated by the administrators themselves, against the intent of Congress, and that if financial interests of other members were taken into account this would probably be much higher.

We are, therefore, asking you, sir, your committee, to consider the amendment of section 1908 so that one or more representatives of the public could be included, and that less than a majority of these boards across the country shall be representatives of a single professional or institutional category; that less than a majority of such boards shall have a financial interest, direct or indirect, in an institution concerned with the care of the chronically ill; and that less than a majority of such boards shall be a combination of owners and employees of institutions concerned with the care of the chronically ill.

I am sure, sir, when the committee has considered this they will feel that it is vitally necessary to meet the intent of Congress and, therefore, I would like to submit this.

Thank you very much for your courtesy, sir, today.

(The statement referred to follows. Hearing continues on page 848.)

STATEMENT OF THE NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, D.C., WILLIAM R. HUTTON, EXECUTIVE DIRECTOR

Mr. Chairman and members of the Senate Finance Commitee:

My name is William R. Hutton and I am Executive Director of the National Council of Senior Citizens, which includes more than two and a half million elderly people organized in senior citizens clubs throughout America.

The President of the National Council of Senior Citizens is Mr. Nelson H. Cruikshank, a distinguished expert on social security, who is well-known to members of this committee as the former director of the Social Security Department of the AFL-CIO.

Mr. Cruikshank had looked forward to the privilege of presenting this testimony here today but when the hearing dates were finally announced we found he had a prior commitment to appear to present a paper before the Inter-

national Senior Citizens Association Convention meeting in Japan. This association was designated recently as one of the consultative organizations recognized by the United Nations Economic and Social Council.

Accompanying me today is Mr. Rudolph Danstedt who is Assistant to the President of the National Council.

With the Chairman's permission I would like to submit for the record, in its entirety, the statement which was to have been presented to the committee by Mr. Cruikshank, plus its attachments.

If this is acceptable to the Chair I would then like to direct my attention to a particularly dark area of the nation's health care—namely, the increasingly serious problem of care of the sick in America's nursing homes.

In particular, I wish to draw the attention of the Senate Finance Committee to a serious situation which has arisen concerning the licensing boards for nursing home administrators set by the States in accordance with Section 1908 of the Social Security Act as enacted in the 1967 amendments.

The intent of the Section 1908 amendment was clearly to safeguard the health and welfare of the nearly two million patients in the nation's nursing homes through the licensing of competent administrators. The licensing boards are charged with developing, imposing and enforcing standards which must be met by individuals in order to receive a license as a nursing home administrator.

The boards develop and apply appropriate techniques for determining whether an individual meets such standards and the boards conduct continuing studies and investigation of nursing homes and administrators to improve the standards so that eventually, the nursing home administrator, after training and professional examinations, can become a licensed professional administrator.

Early this year, reports began to reach the National Council of Senior Citizens that the State Licensing Boards, created in compliance with Section 1908, were being dominated by the Nursing Home Administrators requiring licenses.

On April 14, 1970, I wrote to John D. Twiname, Administrator of the Social and Rehabilitation Service of the Dept. of HEW, to protest against the use of Medicaid funds to pay for nursing care in establishments whose administrators are licensed by agencies dominated by the administrators requiring licenses.

I reported that the National Council of Senior Citizens wanted agencies licensing nursing home administrators to operate in the public interest. We told SRS we favor equal representation of nursing home administrators, other health professionals concerned with the care of the chronically ill, *and the public.*

SRS Administrator Twiname replied on May 8, 1970, that SRS shared our concern and recognized the danger that regulatory boards composed exclusively of members of the group to be regulated, could well perpetuate abuses the nursing home licensure program was designed to eliminate. His letter said, "There is no doubt that both the letter and the spirit of Section 1908 of the Social Security Act reflect the Congressional intent to protect the nursing home patient."

The National Advisory Council of Nursing Home Administration, set up by the 1967 law, recommended that State Boards not contain a majority of members from any one profession.

However, the truth is, the Social and Rehabilitation Administrator who served before Mr. Twiname ignored this advice. On January 29, 1970, this administrator conceded in a letter to Mr. Walter Kyle, past president of the Iowa Nursing Home Association, that a simple majority of members representing one group on the Iowa State Licensing Board would be acceptable, providing the remainder of the Board is representative of the other professions and institutions.

Even though this letter was written to a private citizen in Iowa, it was widely distributed as HEW policy. Unfortunately, to date this letter has not been repudiated by the present SRS Administrator even though in his reply to the National Council on May 8, he has admitted that an "overwhelming majority" of any one group could impair the effectiveness of the board.

The National Council of Senior Citizens has continued to press the Social and Rehabilitation Service for information regarding the composition of State Licensing Boards.

I would like to introduce for the record a letter on this subject I have received from Howard N. Newman, Commissioner, Medical Services Administration. It shows 21 States where Nursing Home Administrators have a dominant majority of the Licensing Boards. In 13 States where Nursing Home Administrators are listed as less than a majority it is not known whether other members of the board have financial interests in nursing homes.

In addition, among boards having less than prescribed powers beyond home administrator licensing, there are eight States (Oregon, Utah, Florida, New Jersey, Nebraska, Rhode Island, Montana and Pennsylvania) where the control of the licensing board is held by nursing home administrators.

Howard Newman's letter quotes one example—in Texas—where by law the board has a simple majority of nursing home administrators (five of a total of nine). Further imbalancing the board, however, the Governor appointed an osteopath who also administered the nursing home as the "physician" on the board. Thus the Texas board has, in fact, six nursing home administrators on a board of nine.

The National Council of Senior Citizens has received evidence of other states where the composition of a board has been altered through the appointment process or by virtue of the fact that other professional members have financial interests in nursing homes.

In our view, more than 60% of the State Licensing Boards for Nursing Home Administrators are being dominated by nursing home administrators—merely from a study of the professions making up the boards. If other professional members were asked to reveal their financial connections with nursing homes, however, the domination of the proprietary nursing home industry over the State Board would, we believe, be revealed as being much higher.

Consequently, the National Council of Senior Citizens urges the Senate Finance Committee to amend Section 1908(b) of the Social Security Act to read as follows:

> (b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of the chronically ill and infirm aged patients [*and of one or more representatives of the public*] and established to carry out the purposes of this section. [*Less than a majority of such board shall be representatives of a single professional or institutional category; less than a majority of such board shall have a financial interest—direct or indirect—in an institution concerned with care of chronically ill and infirm aged patients; and less than a majority of such board shall be a combination of owners and employees of institutions concerned with care of the chronically ill and infirm aged patients.*]
>
> Brackets [] and italics indicate new language.

Regarding the establishment of incentives for States to emphasize outpatient care under Medicaid programs, the National Council of Senior Citizens:

Opposes Section 225(a) which would establish the norm for length of care upon the institutional category of the facility providing the care rather than upon the specific diagnosis of the patient's illness and the condition of the patient.

Opposes Section 225(b) which would establish reimbursement upon the basis of the institutional category of the facility providing care rather than upon the basis of the *actual* care and services provided by the facility to the individual patient.

Urges that the provisions of Section 1902(a)(13)(D) of the Social Security Act as amended by Section 229 of H.R. 17550, which presently apply only to hospitals, should also be made applicable to Title XIX skilled nursing homes and Title XI intermediate care facilities, that is, that the State should be required to pay the reasonable cost—as determined by the State—of the care and services actually provided by the facility to the individual patient.

NATIONAL COUNCIL OF SENIOR CITIZENS, INC.,
Washington, D.C., April 14, 1970.

Hon. JOHN D. TWINAME,
Administrator, Social and Rehabilitation Service, Department of Health, Education and Welfare, Washington, D.C.

DEAR MR. TWINAME: This is to ask that you disapprove State legislation for licensing nursing homes receiving Medicaid funds if the legislation places control of the licensing agency in the hands of the administrators subject to the legislation.

A number of States have enacted laws creating agencies for licensing nursing home administrators under the requirement of Federal law that such agencies be in existence and functioning on or before next July 1 or otherwise be denied Federal funds under the Medicaid program.

Reports reaching the National Council of Senior Citizens indicate the agencies thus being created are sometimes dominated by the nursing home administrators requiring licensing.

I need not remind you of the mounting evidence of maladministration of many nursing homes and the multiplying reports of the exploitation of nursing home patients for profit.

In saying this, our members do not disparage good nursing homes. We honor administrators and other staff members who care for their nursing home patients in the best tradition of the healing profession.

However, lax standards of nursing home care have been called by Dr. David B. Rutstein, Professor of Medicine, Harvard Medical School, "the shame of modern medicine."

Congressman David Pryor of Arkansas, who has worked as a volunteer in nursing homes in Maryland, the District of Columbia and Virginia, reported in a recent speech on the floor of the House of Representatives instances of incredible neglect of patients in the establishments he visited.

A large majority of private nursing homes are run for profit. Our organization is not against profit-making but we *are* against exploitation of the chronically ill, infirm or elderly, so somebody can make a profit.

Accordingly, we protest against use of Medicaid funds to pay for nursing care in establishments whose administrators are licensed by agencies dominated by the administrators requiring licensing. The administrator largely determines the quality of care in a nursing home establishment.

Surely, a necessary first step in providing proper standards of nursing care is to require that nursing home administrators be licensed by an agency that is beyond the influence of the proprietary nursing home industry.

Accordingly, the National Council of Senior Citizens asks that public agencies that license nursing home administrators be so constituted they can function in the public interest.

When the Department of Health, Education and Welfare set up the National Advisory Council on Nursing Home Administration to recommend guidelines for State participation in the Medicaid program, the nine-member Council consisted of three representatives of nursing homes, three representatives of related professions concerned with the care of chronically ill, infirm or aged and three representatives of the public.

Likewise, when the Department created its Task Force on Skilled Nursing Home Care, the Task Force consisted of three representatives of nursing homes, three representativs of related professions concerned with the care of the chronically ill, infirm or aged and three representatives of the public.

The 2,500,000 member National Council of Senior Citizens wants agencies licensing nursing home administrators to operate in the public interest. We favor equal representation of nursing home administrators, other health professionals concerned with the care of the chronically ill, infirm or elderly and the public on such agencies.

We urge you to disapprove State laws that place in the hands of nursing home administrators control over the agencies that license these administrators where Federal funds under the Medicaid program are involved.

Sincerely,

WILLIAM R. HUTTON,
Executive Director.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., May 8, 1970.

Mr. WILLIAM R. HUTTON,
Executive Director, National Council of Senior Citizens, Inc.,
Washington, D.C.

DEAR MR. HUTTON: This is in reply to your letter of April 14, 1970, expressing your views on the composition of State boards established to administer the nursing home administrator licensure programs.

We share your concern and recognize the danger that regulatory boards, composed exclusively of members of the group to be regulated, could very well perpetuate abuses the nursing home administrator licensure program was designed to eliminate. There is no doubt that both the letter and the spirit of Section 1908 of the Social Security Act reflect the Congressional intent to protect the nursing home patient.

In general, we believe that in establishing standards for an emerging profession, such as nursing home administration, it is most desirable to have as broad representation as possible in the board membership. An overwhelming majority of representatives from *any one* professional or institutional group might tend to submerge the board with many preconceived concepts, some of which might already be outmoded by research and the rapid advances in the field of geriatrics and gerontology.

While the Department of Health, Education, and Welfare does not approve or disapprove State nursing home administrator licensure legislation, the program as it is administered by the State board, must adhere to the provisions of Section 1908 of the Social Security Act and the Department regulations as published in the *Federal Register* on February 28, 1970.

Sincerely yours,

JOHN D. TWINAME,
Administrator.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., September 10, 1970.

Mr. WILLIAM R. HUTTON,
Executive Director, National Council of Senior Citizens, Inc.
Washington, D.C.

DEAR MR. HUTTON: Thank you for your letter of September 8, 1970 regarding the composition of State boards established to administer programs of licensure for nursing home administrators in compliance with Section 1908 of the Social Security Act. The compilation which I referred to in my letter of June 12 was completed August 20, 1970.

Using information available up to that date, it appears that the boards in 21 of the existing 47 programs have a majority of nursing home administrators.

I would welcome a visit from you to discuss this subject in detail.

Sincerely yours,

HOWARD N. NEWMAN,
Commissioner.

Enclosure.

REPORT AND ANALYSIS OF THE COMPOSITION OF STATE BOARDS OF LICENSURE FOR NURSING HOME ADMINISTRATORS

Of the 50 States and four territories of the United States, two States—Alaska and Arizona—do not participate in the title XIX (Medicaid) program, and two territories—Guam and the Virgin Islands—have no nursing homes. These four jurisdictions are therefore not obliged to have programs for licensing nursing home administrators.

Of the 48 States and two territories that are required to have programs for licensing nursing home administrators by July 1, 1970, three have not yet enacted enabling laws. These are California, Massachusetts and Puerto Rico.

Thus, there now exist 47 programs for licensing nursing home administrators. Thirty-six of these programs include nursing home administrator licensing (nha/1) boards having substantially the powers, duties and functions prescribed by Section 1908(c) of the Social Security Act; seven assign the licensing of nursing home administrators to a State department, an agency, or a board of health; and four have nursing home administrator licensing boards which have substantially less than the prescribed powers, duties and functions. In these four cases a department, an agency, or a board of health assumes major responsibility or power of review.

The composition of two of the 36 "real" nursing home administrator licensing boards is not specified in State law. Of the 34 "real" boards whose composition is more or less clear in the statute, 21 have a majority of nursing home administrators as members, and 13 have less than a majority of nursing home administrators. That is, of the 34 "real" boards whose composition is statutorily defined, 21 have a membership that reflects a clear majority of nursing home administrators. (Table I)

As important as the fact of domination by nursing home administrators is the number of representatives of other professions, agencies or the public on the boards. Of the 21 boards dominated by nursing home administrators, two have only one other member, six have two other members, and six have three other members. A total of 15 of the 21 boards having a majority of nursing home administrators have three or fewer representatives of other professions, agencies or the public. Nine have two or one. (Table II)

It should be noted that it is possible to alter the statutory composition of a nursing home administrator licensing board through the appointment process. There are a number of ways this can be done, but the case of Texas is illustrative.

Texas' law calls for a nine member board appointed by the Governor consisting of two State officials (ex officio), one physician, one educator, and five nursing home administrators. By law the board has a simple majority of nursing home administrators (five of a total board of nine). Further imbalancing the board, however, the Governor appointed an osteopath *who also administers a nursing home* as the "physician" on the board. The Texas board thus has, in fact, six nursing home administrators on a board of nine members, resulting in a 2-to-1 ratio of nursing home administrators to all other members.

This sometimes subtle altering of the composition of a board through the appointment process is not by any means unique to Texas, although its extent has not yet been fully determined.

In some cases State laws specify that a nursing home administrator be also representative of another profession. New Jersey's law, for example, specifies that one of the nursing home administrators on the board be a physician, and two of them be nurses. In this analysis we have considered the occupation of "nursing home administrator" as the primary basis for classification, and have noted other professional qualifications or representation in footnotes. This has been done for analytical purposes, but it is possible to argue that the occupation of "nursing home administrator" is paramount for practical policy-making purposes as well.

TABLE I

Jurisdiction having no program for the licensure of nursing home administrators:

1. Alaska	No title XIX
2. Arizona	No title XIX
3. Guam	No nursing homes
4. Virgin Islands	No nursing homes
5. California	No law
6. Massachusetts	No law
7. Puerto Rico	No law

Jurisdictions assigning the licensing of nursing home administrators to a State department, an agency, or a board of health:

1. Arkansas	Board of Health, w/Advisory Council (AC).
2. D.C.	Commission on Licensure to Practice the Healing Art, with discretion to appoint a nha/1 board and AC.
3. Hawaii	Department of Health
4. Kansas	Board of Health
5. Michigan	Department of Licensing and Registration, w/AC.
6. Oregon	Board of Health
7. Utah	Department of Registration

Jurisdictions having nursing home administrator licensing with substanially less than prescribed powers, duties, and functions, a State department, an agency, or a board of health having major responsibility or powers of review:

1. Florida	Nursing Home Council, subject to review by State Board of Health.	5 nha's of 9 members.
2. New Jersey	nha/l board, but the State Board of Control appears to have final authority and powers of review.	7 nha's of 9 members.[1]
3. Nebraska	Department of Health with 3 member board "for purpose of giving examinations".	
4. Rhode Island	nha/l board, but major functions assigned to Department of Health.	5 nha's of 5 members.

[1] New Jersey—1 physician and 2 nurses who are also nursing home administrators.

"Real" nursing home administrator licensing boards, composition not specified in law:

1. Montana	nha/l board	5 members appointed from a list of 9 names (including nha's and rep's of university units) submitted by MNH Association (and 2 nonvoting members).
2. Pennsylvania	nha/l board, w/AC	Composition not specified, refers to nha/l board as "departmental administrative unit in Department of State".

"Real" nursing home administrator licensing boards with less than a majority of nursing home administrators as members as specified in the State law:

1. Delaware	Nursing home administrator's/l board	3 nursing home administrators of 7 members.
2. Indiana	do	5 nursing home administrators of 11 members
3. Kentucky	do	4 nursing home administrators of 9 members.
4. Louisiana	do	4 nursing home administrators of 10 members.
5. Maine	do	3 nursing home administrators of 7 members.
6. Maryland	do	4 nursing home administrators of 9 members.
7. Minnesota	do	4 nursing home administrators of 9 members and 2 nonvoting members.
8. Mississippi	do	3 nursing home administrators of 7 members, and 1 nonvoting member.
9. Missouri	do	4 nursing home administrators of 9 members.
10. New Hampshire	do	Do.
11. South Carolina	do	Do.
12. West Virginia	Nursing home/l board with AC	2 nursing home administrators of 9 members.
13. Wisconsin	Nursing home administrator's/l board	4 nursing home administrators of 9 members, and 1 nonvoting member.

"Real" nursing home administrator licensing boards with a majority of nursing home administrators as members, as specified in the law:

1. Alabama	Nursing home administrator/l board with AC.	5 nursing home administrators of 9 members until July 1, 1975, then 7 of 11.
2. Colorado	Nursing home administrator/l board	5 nursing home administrators of 9 members.
3. Connecticut	do	Do.
4. Georgia	do	7 nursing home administrators of 13 members.
5. Idaho	do	3 nursing home administrators of 5 members.
6. Illinois	do	5 nursing home administrators of 7 members.
7. Iowa	do	5 nursing home administrators of 9 members.
8. Nevada	do	3 nursing home administrators of 5 members.
9. New Mexico	do	4 nursing home administrators of 5 members.
10. New York	Nursing home administrators/lboard with AC.	6 nursing home administrators of 11 members
11. North Carolina	do	3 nursing home administrators of 5 members. (and 1 nonvoting member).
12. North Dakota	Nursing home administrators/l board	5 nursing home administrators of 9 members.
13. Ohio	do	At least 4 nursing home administrators of 7 members.[1]
14. Oklahoma	do	7 nursing home administrators of 9 members
15. South Dakota	do	4 nursing home administrators of 5 members.[2]
16. Tennessee	do	6 nursing home administrators of 9 members.
17. Texas	do	5 nursing home administrators of 9 members.
18. Vermont	do	6 nursing home administrators of 9 members.
19. Virginia	do	4 nursing home administrators of 7 members.
20. Washington	do	6 nursing home administrators of 9 members.
21. Wyoming	do	3 nursing home administrators of 5 members.

[1] Ohio—the board as appointed has 5 nursing home administrators out of 7 members.
[2] South Dakota—1 nurse who is administrator or director of nursing services in a nursing home (Appointed a nursing home administrator with an R.N. degree).

TABLE II

Rank order of boards on which there are by law a majority of nursing home administrators, by number of "others" on board:

	States
1. 1 "other", 4 nha's of 5 members	2
2. 2 "others", 7 nha's of 9 members	1
5 nha's of 7 members	1
3 nha's of 5 members	4
3. 3 "others", 6 nha's of 9 members	4
4 nha's of 7 members	2
4. 4 "others", 5 nha's of 9 members	5
5. 5 "others", 6 nha's of 11 members	1
6. 6 "others", 7 nha's of 13 members	1
Total	21

TABLE III

Rank order of boards on which there are by law a majority of nursing home administrators, by percentage of board which is nursing home administrators:

1. 80.0 percent	4 nha's of 5 members	2 States.
2. 77.8 percent	7 nha's of 9 members	1 State.
3. 71.4 percent	5 nha's of 7 members	1 State.
4. 66.7 percent	6 nha's of 9 members	4 States.
5. 60.0 percent	3 nha's of 5 members	4 States.
6. 57.1 percent	4 nha's of 7 members	2 States.
7. 55.6 percent	5 nha's of 9 members	5 States.
8. 54.5 percent	6 nha's of 11 members	1 State.
9. 53.8 percent	7 nha's of 13 members	1 State.
Total		21 States.

STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS (REPRESENTED BY WILLIAM R. HUTTON, EXECUTIVE DIRECTOR)

Mr. Chairman, Members of the Senate Finance Committee: I take special pleasure in presenting testimony before you today in a new role. On many occasions during past years, I have had the privilege of appearing before this Committee as Director of the Social Security Department of the AFL-CIO. Today, I present testimony as President of the National Council of Senior Citizens, an organization which has 2,500 clubs and over two and one-half million members.

After long years dedicated to the promotion of the interests of our working population, I am proud to now have an opportunity to devote my efforts to the interests of our older citizens. These are mutual interests, especially with respect to Social Security, and I have needed only to shift focus, not goals.

With your permission, I would like to provide just two examples of recent actions by the National Council of Senior Citizens that indicate a broad concern and sense of responsibility going far beyond self-interest.

On June 11–13 here in Washington, more than 1,500 delegates to our Ninth Annual Convention formulated—out of their vast experience, wisdom and wholehearted conviction—a well-rounded package of resolutions on matters of urgent national concern. I take pride in reporting that these delegates conducted themselves as responsible citizens first, as seniors secondarily.

As a consequence, many of the resolutions adopted were aimed at a better society for all our people, not just for the elderly. Included, for example, were resolutions for reordering our national priorities, for pollution control, and for extension of the voting rights act to our younger citizens aged 18 to 21.

My other example relates to the position taken by the National Council on the specific question of the retirement test in Social Security. As Members of the Congress know all too well, this is the least understood and most criticized feature of a program that has earned wide acceptance and support by the American people. It would have been easy for the National Council to choose the popular path of advocating elimination of this test. Our members are active and vigorous and many of them need whatever earnings they can get in order to eke out inadequate Social Security benefits. But after careful study, the National Council endorses retention of a liberalized test because complete

elimination would significantly increase the Social Security taxes paid by our working population. The Council believes that increased taxes could better be used to raise benefits for those unable to earn.

This position demonstrates the National Council's keen awareness of the pressures on the pay check of today's worker—his obligations to his own family plus his costs for supporting the older population so that he in turn will be supported in his old age by that working population. Our members take their responsibilities as grandparents seriously; they would unhesitatingly defer to the claims of the oncoming generations were our national resources so limited as to make a choice necessary. And as mothers and father, they want a much better old age for their children than they themselves now have. Their own demands are modest, far more modest than will be the expectations of future generations of retirees. But they know too that economic gains made by older people today are gains for the retirees of tomorrow.

I believe that much of the strength of America derives from this strong sense of family responsibility. And I believe that a strong Social Security system strengthens, rather than weakens, family responsibility in its best sense. This is the message that I attempted to convey in a working paper entitled "The Stake of Today's Workers in Retirement Security," which I prepared for the Senate Special Committee on Aging as part of its study of the "Economics of Aging: Toward a Full Share in Abundance."

With respect to economic security and the modern family, I said:

> And the time has long since gone when the grandparents in each family lived with and were supported by the parents of that family. Support of one generation by another is now provided, not within families, but between one whole generation and another. The generation now in the labor force supports the generation of retirees so that it in turn can be supported in retirement by those then productive. This transfer of incomes between generations is now achieved primarily through governmental and institutional arrangements rather than within family units. Payroll deductions and social insurance are simply the mechanism by which an industrial society implements these transfers.

In this working paper I stressed an important fact—frequently overlooked—that "*Social Security is family security,*" saying:

> Too often we forget—or have never realized—that the payroll taxes we pay for Social Security are providing not just assurance of income in old age but also current protection against loss of earnings through death or disability.

I need not detail the facts set forth in this working paper—some of which I shall use with specific reference to the bill now under consideration—facts which justified my conclusion:

> Bold new steps are long overdue, steps that would immediately enable today's retirees to share in the abundance they helped to create and that would assure to future retirees—today's workers—an income that is adequate in relation to their standard of living prior to retirement. Such assurance can be provided only through major improvements in our time-tested Social Security system.

The Senate Finance Committee now has an opportunity to take the bold new steps that not only would immediately provide real economic security for over 20 million people who are already old, but would strengthen the current protection of today's workers against disability or death and their future protection in old age. In commenting specifically on H.R. 17550 in relation to these objectives, I shall first direct my testimony to the cash benefit provisions.

SOCIAL SECURITY CASH BENEFITS

H.R. 17550 falls far short of the bold reform needed in order that our Social Security system can be a truly viable method of assuring both present and future retirees of a fair share in the economic abundance they have helped to create.

The changes proposed by H.R. 17550 are essentially of two types. There is what I consider the "patchwork" type: a five percent increase in benefits, a widow's benefit equal to the primary benefit, removal of the inequity in the computation of early retirement benefits for men, and liberalization of the retirement test. With the reservation that the five percent increases is inadequate even for purposes of "catching-up", there are badly needed improvements which we support.

H.R. 17550 also includes desirable innovative features aimed at reform: automatic adjustment of benefits to recognize increases in the cost of living; automatic adjustment of the wage base that is taxed and credited for future benefits; and automatic upward adjustment in the amount beneficiaries may earn without loss of benefits. We wholeheartedly endorse the principle of automatic adjustment but urge that such adjustment be pegged to a higher benefit level and a higher maximum on the wage base.

The shortcomings of H.R. 17550 can be briefly summarized. First and this is of tantamount importance to today's aged—it fails to provide the substantial increase in benefit levels that should *precede* automatic adjustment. Second, by not raising the wage base significantly, it fails to assure future retirees that their benefits will be reasonably related to their previous earnings—failing, at the same time, to provide more income to the system and to reduce the regressivity of the tax. Finally, H.R. 17550 fails to take the bold step of using general revenues as a more equitable basis for sharing the costs of Social Security.

It is to these failings of H.R. 17550 that I shall direct my testimony.

The National Council of Senior Citizens urges that the Senate, building upon the many desirable features of H.R. 17550, take this opportunity to make the other major improvements that are long overdue in a dynamic economy.

I would like to preface my specific comments by including at this point excerpts from the resolution in Social Security Cash Benefits, adopted unanimously at the 1970 Convention of the National Council of Senior Citizens. I ask that the complete text of the resolution be included in the record of this hearing.

This resolution, framed against a recognition of the progress that had been made since the Convention a year earlier—the 15 percent increase in benefits and the proposed improvements in the bill passed by the House—reads in part:

> Whereas, despite this progress, an estimated 5-7 million Social Security recipients still remain impoverished, a situation that can only be remedied by the Gilbert-Williams bill with its proposals for substantially raising minimum benefits and an across-the-board increase of another 35% in Social Security benefits, phasing in of an increase in the wage base up to $15,000, and a contribution from the general revenues that would eventually provide for one-third of the cost of the benefits; now, therefore, be it
>
> *Resolved*, That this Ninth Convention of the National Council of Senior Citizens HEREBY expresses its appreciation to the Members of Congress for the action taken in this 91st Congress with respect to increased benefits and other improvements in Social Security; be it
>
> *Resolved*, This Convention considers the 15% increase of January, 1970, and proposed increases as a down payment on those benefits proposed in the Gilbert-Williams bill and reaffirms its support for the Gilbert-Williams bill which provides for a further 35% increase in benefits by 1972 for present and future retirees and utilization of general revenue funds to finance a portion of the cost, thus avoiding undue burden on workers with low incomes.
>
> This Convention supports the inclusion of an automatic cost-of-living adjustment as a principle so long as it is recognized as a matter of public policy that there also be adjustments in future benefits to recognize rising productivity and standards of living."

The benefit level

I will first address my comments to the benefit level proposed in H.R. 17550 and consequences of adopting the specific cost-of-living escalation provision the bill proposes.

The level for today's aged.

Automatic adjustment would start in 1972 at today's level of benefits plus 5 percent—and I need not point out that the 5 percent is less than the annual rate of increase in prices we have been experiencing. In simplest terms, the consequence is this: *just as many beneficiaries will remain just as poor as they now are.* They are trapped by a guarantee of poverty. Their financial condition may get worse—indeed, it is likely to, as advanced age and deteriorating health deplete whatever resources they may have in addition to their benefits; it will not get better. They are literally frozen into poverty.

Let's look at the level of income at which H.R. 17550 would freeze our elderly beneficiaries—and I use "freeze" advisedly because I take little comfort from the statements by the Administration to the effect that once automatic adjustment is legislated, the Congress will be able to give full time and attention to the question of benefit adequacy.

According to the Social Security Administration's 1968 Survey of the Aged, 44 percent of all people over 65 had income below the poverty level in 1967; for another 11 percent, incomes fell below the "near-poor" level. Even of the couples receiving Social Security benefits, more than one-fifth (22 percent) had total incomes of less than $2,020 and would therefore have been classified as poor on the basis of the 1967 income thresholds developed by the Social Security Administration. Nearly three out of every five nonmarried beneficiaries had incomes below the poverty threshold of $1,600. In round numbers, this amounts to almost 6½ million elderly beneficiaries—an appalling total in a nation that takes pride in its Social Security system! Admittedly, benefits have been increased since 1967, but these increases have done little more than catch up with price rises. Admittedly too, not all of these beneficiaries live in poverty. Many—especially the widows and other nonmarried beneficiaries—reside with adult children, thereby escaping poverty albeit at the price of dependency. Dependency. Desirable as such living arrangements may be, maximum mutual satisfaction can be achieved only if free of economic necessity. Our older people have a *right* to enough income to enable them to live in dignity and financial independence.

Furthermore, new evidence shows that the number of aged people living in poverty actually *increased* from 4.6 million in 1968 to 4.8 million in 1969. And there are indications that the rise in poverty among the over-65 population now reflects more aged men who are poor—possibly because they had to claim reduced Social Security benefits before reaching age 65; (in the past the increase has been concentrated among aged women living alone and was attributed to their desire for independence even if purchased at the price of poverty).

In urging that the Congress now enact a *meaningful* increase in the level of Social Security benefits, I would suggest that we reexamine the basic premise upon which the Social Security Act was formulated more than a third of a century ago when the nation was acutely suffering from a gigantic depression. At that time, our economy had no place to go but up! Benefits were purposely designed to provide only a bare subsistence of living because it was assumed that beneficiaries of the future would have significantly more income than did those already old. Except for people with greater than average needs and lower than average resources, the social insurance benefit would in due time eliminate the need for public assistance.

How does the present situation stack up against these expectations? National economic growth has vastly outstepped our most optimistic hopes. But the aged population's share in the nation's prosperity has lagged far behind.

The Social Security benefit remains the major source of income for most retirees today. One-fourth of the aged couples on the Social Security rolls at the end of 1967 and two-fifths of the nonmarried beneficiaries depended on Social Security for almost their entire support—for all but $300 per person for the year. And, significantly, there had been little improvement in this respect since the incomes of aged beneficiaries were surveyed a decade earlier.

What does H.R. 17550 do to raise these benefits that are the lifeblood of our aged citizens? The 5 percent increase—in combination with other improvements, would raise the average benefit for retired workers to $129 a month, for aged couples to $218 and for aged widows to $123. The new minimum for unreduced benefits would be raised to the munificient amount of $67.20, and this minimum is all that many workers have been able to qualify for—as many as one-sixth of all the retired workers on the rolls at the end of 1969 were receiving the minimum or less.

Benefits for workers now coming on the rolls average somewhat higher than these amounts. These present retirees are also more likely to have income from other sources—a private pension plan, for example, or income from assets that have not yet been exhausted, or from part-time employment after retirement.

Benefits level for future retirees

Any complacency about great improvement in the income position of the elderly for the immediate future is quickly shattered by the following findings reported in the working paper, "The Economics of Aging: Toward a Full Share in Abundance," which launched the Senate Committee on Aging's study of the retirement income crisis:

> Projections to 1980 indicate that about half the couples and more than three-fourths of the unmarried retirees will receive less than $3,000 in total pension income. And these projections use relatively liberal assumptions with respect to increases in private and public benefit levels.

> The same projection found that more than two-thirds of retired couples could be expected to receive less than $3,000 in Social Security benefits in 1980.
>
> Even under earlier projections, now known to be too optimistic, only a third to two-fifths of all aged persons were expected to have income from private group pensions by 1980.

The conclusion is inescapable. As I pointed out in the working paper which I prepared for the Senate Committee on Aging:

> It is for reasons like these that present inadequacies in retirement income—and the policies and trends that perpetuate them—are of urgent and direct concern to all workers and not just to our aged population.
>
> Social Security, now the basic underpinning of retirement security, will continue to be the major source of income for most older people and the level of benefits will largely determine their share in economic abundance.

Proposed reform

We therefore urge the Congress to enact the *meaningful* increase in benefit levels originally proposed by Senator Williams and Congressman Gilbert along with numerous cosponsors in their identical bills (S3100 and H.R. 14430) and reintroduced by Senator Williams as Amendment No. 756 to H.R. 17750, the 1970 Social Security bill passed by the House.

Among the major reforms proposed are the following changes which would raise the benefit level, now and for the future.

First, an immediate increase of 10 percent in monthly cash benefits, with a further 20 percent increase effective January 1, 1972. This two-step increase would raise the minimum benefit to $120 a month in 1972. Second, *thereafter*, automatic increases geared to increases in living costs. Third, to assure that workers retiring in the future will receive benefits more reasonably related to their past earnings, and increase to $15,000 a year now—automatically adjusted *thereafter* to rising wage levels—in the amount of earnings taxed and credited for benefits, with benefits based on ten years of the 15 years of highest earnings.

We feel strongly—and so stated at our national convention—that adoption of a cost-of-living escalator should be accomplished by a clear statement of public policy assuring that there will also be future adjustments in benefits to recognize rising productivity and standards of living.

Relation of the benefit level to the retirement test

I would like to make one final point about the benefit level. A more nearly adequate benefit level would, in my opinion, be important in gaining public acceptance of the unpopular retirement test.

We all recognize the need to improve the retirement test, and I commend this Administration for proposing the type of test included in the House-passed bill. As compared to previous proposals, the reformed test has the advantage of simplicity and ease of understanding. It assures that no beneficiary loses by taking part-time jobs, at the same time that it conserves our Social Security funds for the payment of benefits to persons unable to work.

With an improved benefit level, many workers will no longer feel that it is absolutely necessary to compete for jobs in order to supplement inadequate retirement benefits.

I am fully aware of the psychological advantages of continuing to engage in worthwhile activity after retirement. But the value of this activity should not be measured solely by its monetary return. I am a case at point: as President of the National Council of Senior Citizens, my services are unpaid; by some standards, my services are therefore worthless—a judgment I refuse to accept.

I believe that after people have made their contribution to our market economy through 40 or 50 years of hard work, they should be assured a retirement income that frees them from the necessity of the pressures of the economy and permits them to create other values—values related to their social usefulness. With an improved benefit level, retired workers could—and I am sure, would—turn their talents and wisdom to socially useful endeavors.

The Wage Base

As the resolution adopted at our annual convention indicates, an increase in the wage base is also an essential to reform of the Social Security system. The maximum placed on the amount of earnings taxed and credited for benefits is of primary concern to workers who will retire in the future, rather than to those already retired. Nevertheless, the National Council of Senior Citizens—

because its members are wholeheartedly committed to assuring future retirees of a better future than they themselves now enjoy—has a strong position on this subject.

The National Council therefore urges that the Congress raise the maximum on the wage base to $15,000 before instituting the automatic provisions that would keep the system in step with rising earnings.

The House-passed provision that would raise the maximum to $9,000 merely maintains the relationship established in 1950. One out of every five covered workers would still have annual earnings for which they did not receive credit; about one-fifth of all earnings in covered employment would be untaxed. Today a maximum of at least $15,000 is needed to restore the relationship of the original Social Security Act, when fewer than 5 percent of all four-quarter workers had earnings above the maximum then in effect ($3,000).

Modernization of the system with respect to the wage base—and this is indeed modernization, even though it goes farther back in time to reinstate an earlier relationship—is important for two reasons. First, it strengthens the financing of the system by producing more revenue and by reducing the regressivity of the tax. Second, it assures future retirees of benefits that are more reasonably related to past earnings and thus would necessitate a less drastic reduction in the standard of living which they achieved as workers.

Use of general revenues

Again, the National Council of Senior Citizens goes back to the early history of Social Security as a basis for recommending that the financing of the system be reformed through the use of general revenues.

The President's Committee on Economic Security, which drafted the outlines of the Social Security Act adopted by the Congress in 1935, recommended that the system be supported out of general tax sources. The purpose of the proposed contribution from general revenues was to make up the deficits resulting from the payment of larger benefits to workers already close to retirement than could be financed through their own and their employers' contributions. As enacted in 1935, however, the Social Security system was completely self-supporting, requiring the building up of huge reserves during the early life of the program. In 1943, the Congress—faced with the alternatives of repeatedly freezing the contribution rate or piling up a tremendous trust fund—authorized a contribution out of general revenues in the event that the lower contribution rates were insufficient to pay scheduled benefits. This provision remained in effect until 1950 when a new schedule of higher rates was adopted.

Thus, the Congress has recognized over the years that under some circumstances financing of part of the costs of the Social Security system out of general tax revenues would be desirable. The Congress has also actually provided for use of government contributions to meet the specific costs of wage credits for military service, hospital insurance for the non-insured, matching funds for the Part B premium, and costs of the age-72 special benefits. Nevertheless, workers, through their contributions to the system, have been helping to shoulder the costs of paying full benefits to retirees who were already close to retirement age when the system was first started or when coverage was extended to their employment.

We do not question the fact that each generation of workers bears the burden of supporting the nonproductive population, whether older or younger. What we question is the method of financing these costs.

As I said in the working paper prepared for the Senate Committee on Aging:

> The costs of supporting our aged population are already large and will have to be much larger to assure old people a full share of the Nation's economic abundance. The working population cannot escape these costs. Workers of all ages, therefore, have a vital stake in making sure that the financial burden is spread in the most equitable manner.

In testifying before this Committee, I need not belabor the question of the regressivity of the Social Security tax—when considered just as a tax and without regard to the offsetting effect of the benefit formula. I need only say (and this is from my long years of cherished affiliation with organized labor as well as from my present association with concerned seniors) the time will soon be reached—if it is not already here—when it will be very difficult to levy a regressive tax on law-paid workers at the higher rates needed to finance the essential improvements in our Social Security system.

The National Council of Senior Citizens therefore urges the Congress to adopt the provision of the Williams-Gilbert bill for financing a share of the costs of

Social Security through general revenues. The specific provisions of this bill have been carefully designed to assure, through a gradually rising percentage of payroll taxes, that general revenues would assume one-third of the long-run costs of this program. This is the share attributable to what in a private pension system would be called the "accrued liability", the cost of paying full benefits to the generation for whom the social insurance system would otherwise have been too late and who would therefore have had to look for their support to public assistance financed by general revenues.

HEALTH CARE AND MEDICAL COSTS

I would like to preface our specific comments on the provisions of H.R. 17550 that relate to Medicare and Medicaid by a few general observations about these two important programs in relation to our nation's overall need for an improved system of health care delivery, especially as this system relates to the aged.

Our nation's health care system badly needs organization and improvement. Whatever can be done to improve the system for one group in the population will improve the system for all others. Whatever can be done to contain costs affects not only the taxes and premiums paid for Medicare and Medicaid but the amounts paid out-of-pocket or for health insurance by both young workers and the retired.

Because we believe that the future of health care for the aged rests essentially on the future of health care for the total population, the National Council of Senior Citizens endorses legislative proposals for a comprehensive National Health Program for all Americans, financed through the Social Security system supplemented by general revenues. The resolution adopted at our 1970 Convention is included for your record of this hearing.

Until our Nation adopts a program of health insurance for all Americans, the elderly population will continue to look to Medicare and Medicaid for help in financing health costs that are close to triple those of younger persons during a period when incomes are reduced to half or less. It is therefore imperative that these programs be strengthened and improved, not weakened. It is also imperative that instances of abuse or unsatisfactory performance be viewed in proper perspective and dealt with in a way that avoids creating the negative public impression that would impede improvements in the programs.

The National Council recognizes that sky-rocketing medical costs, as well as evidences of overcharging and abuses of these programs, call for effective cost controls.

We therefore support the efforts by this Committee together with the House Ways and Means Committee and the Administration to control costs and to improve the delivery of health services. Should these efforts to control costs be insufficient—and if there is continuing evidence of lack of self-discipline on the part of the medical profession and providers of services—the National Council of Senior Citizens, as an organization and through its membership, will continue to press for more effective measures.

But we strongly urge that whatever controls are adopted be carefully designed so as not to limit the benefits or penalize the patient.

Nursing homes

To illustrate this point, I need only cite our concern in relation to nursing homes and long-term care. That this is an overwhelming concern of older people is clear from the attention devoted at our recent national convention. Three major resolutions were adopted on the specific subjects of "Safety in Nursing Homes," "Intermediate Care Facilities," and "Exploitation and Abuse of the Elderly Sick." (With your permission, I submit these Resolutions for the record.)

We appreciate the importance of changes in the Medicare and Medicaid programs that would encourage the use of less expensive forms of medical care and that would assure that patients do not remain too long in institutional settings. All too often, however, alternative forms of health care are not available, especially for our oldest people who lack homes in which health services could be provided. At present, health care is fragmented. We have not been sufficiently innovated in developing new approaches that provide coordinated care at the level appropriate to the patient's needs.

The only real solution to this problem is to assure that there are genuine alternative arrangements suited to the needs of the patient. The problem is

compounded, not solved, if restrictions in the Medicare and Medicaid programs place heavier burdens on those who can least afford to bear the burden of these costs.

I turn now to comments relating to Medicare.

Medicare

Members of the National Council of Senior Citizens feel particularly identified with Medicare since they served in the front line trenches during the long battle to achieve health insurance for the aged. Our organization views with pride the significant role it played in the enactment of a program of immeasurable value in relieving older people of part of the crushing burden of medical costs.

We view with pride too our efforts to fulfill the promise of Medicare. Through the project Medicare Alert, we sought out and enrolled thousands of older people who might otherwise not have known of the valuable protection to which they were entitled. And in the ensuing years, our members have acted individually as responsible citizens, careful not to abuse the protection offered by the program because they realize full well the value of its benefits.

Because the National Council takes pride in Medicare, we offer today suggestions for specific improvements. These recommendations were given high priority at the National Council's Ninth Annual Convention on June 11–13. With your permission I would like to introduce for the record the full resolution adopted by the more than 1,500 delegates at this Convention and to share with you our objectives.

Health maintenance organizations

With specific reference to H.R. 17550, we view the proposal for a health maintenance organization option as a significant contribution to improved organization and delivery of health services, achieving comprehensive and coordinated care for the patient and at the same time efficiency and economy in the use of the nation's health resources. Some of our members were among the pioneers in the development of prepaid group practice plans. They welcome the opportunity for broader development of such plans so that more of our seniors can share in the benefits to be derived from this method of organizing health care.

To encourage the development of HMO's and to encourage beneficiaries to enroll in such organizations, the legislative proposal should be revised to provide greater incentives than are now proposed. Specifically, the proposal now requires that HMO's provide health services equal in quality and scope to those of the Medicare program but at not more than 95 percent of comparable Medicare costs in the community. We strongly urge that HMO's be reimbursed at the full amount of the 95 percent of comparable Medicare costs, with appropriate assurances that the income in excess of costs will be used to provide incentives for beneficiaries to enroll in this option. These incentives would include items not covered by Medicare, for example, deductibles and coinsurance, eye examinations and physical examinations.

There are other amendments to the proposal that are needed to achieve the fullest development and expansion of health maintenance organizations capable of efficiently delivering high quality care at economical cost. On such amendments, both technical and substantive, the National Council would defer to the recommendations of representatives of these health maintenance organizations.

Chiropractic services

H.R. 17550 contains a provision that would require a study of chiropractic services provided by State Medicaid programs in those States that authorize such services, for use in determining whether chiropractic services should be covered by Medicare. The National Council of Senior Citizens, while unequivocally opposed to including chiropractic as a reimbursable service under the program, is, of course, not opposed to this study. We urge, however, that the study pay specific attention to the important question of whether the use of chiropractic services results in not using—or in postponing—medical services when medically indicated.

Objectives relating to Medicare

To maximize the availability of health services to the elderly, the National Council of Senior Citizens call for removal from Medicare of all the financial barriers and coverage gaps that continue to either limit or deny adequate health protection to the elderly. The specific improvements in Medicare which we consider of highest priority are contained in the identical bills introduced by Senator

Williams of New Jersey and Congressman Gilbert of New York. These bills would extend coverage to out-of-hospital drugs, provide Medicare coverage for disabled beneficiaries, and—by combining Part A and Part B—relieve individuals living on small fixed incomes of the burden of paying ever-rising premiums for Part B protection (premiums that have risen nearly 80 percent in less than four years). We believe strongly that Medicare benefits, like cash benefits of Social Security, should be financed during a person's working life and be paid during the non-working years as a matter of earned right.

Medicaid

The National Council of Senior Citizens views with alarm the proposed amendments that would downgrade Medicaid: first, by repealing the requirement in present law that States must have comprehensive Medicaid programs by 1977, and second, by reducing federal matching for long-term institutional care.

In our view, the first of these amendments says, in effect, that Medicaid is expendable—that the mere promise of the Administration to develop a proposal for a Family Health Insurance Plan by February, 1971, is sufficient excuse for phasing out, instead of improving the existing program of medical assistance. Yet the proposed health insurance program will relate only to families with children on FAP! It offers no hope to the millions in the adult categories who are receiving cash assistance because of age, blindness, or other disability, or to millions of older people who may be medically needy. It will do nothing for older women who are widowed and become dependent in their late fifties or early sixties. It will do nothing for workers who are eased out of the labor force long before age 65 and have to claim reduced Social Security benefits. These older people who are under age 65, and thus ineligible for Medicare, will continue to be completely dependent upon Medicaid for medical expenses that are beyond their financial reach.

Even for those 65 and older, who are fortunate enough to have the protection of Medicare, a strong and improved program of Medicaid is essential. Medicare covers less than half the total costs of medical care for the aged population, leaving this group with medical bills that average higher than the average bill of the younger person. And Medicare covers a much smaller proportion of the medical bill for those aged who have heavy costs for drugs and the chronic conditions that plague older people or who need long-term care in nursing homes where all too many of the aged spend their last months—or years.

For all of these older people, an improved and expanded program of Medicaid is essential, at least until this nation has comprehensive health protection for people of all ages.

The second amendment that gives us cause for grave concern would increase the federal sharing in costs for outpatient and home health services—a most commendable change if it achieves the objective of expanding home health care that is now unavailable in many parts of the country. But at the same time, it would reduce the federal sharing in long-term care, the very essence of the health care needs of the aged and a need that the Medicare program does not now pretend to cover. Specifically, this proposal would cut by one-third the share of federal matching funds going to a general or TB hospital after 60 days of inpatient care and to a mental hospital after 90 days. It would cut the federal matching funds by one-third after a patient has spent 90 days in a nursing home with further cuts with longer stays of the patient—this despite the fact that more than two-thirds of all nursing home patients are found to require more than 90 days of care.

This amendment has been explained in terms of a "reordering of priorities," an emphasis on less expensive outpatient care. Yet the vast majority of Medicaid patients who are in nursing homes and mental institutions have no home of their own and no family with whom they can live. The cutback in the federal obligation that was assured with the enactment of Medicaid—an obligation that recognized the inability of the states to carry this burden—would inevitably result in a sharp reduction in the availability and quality of care of patients in nursing homes and other long-term facilities. And the elderly would be especially hard-hit.

Why—when priorities are "reordered"—why must it always be the aged population that drops to a lower level?

One final comment on Medicaid.

Secretary Richardson, in his July 14, statement to this Committee, said:

> The "sudden death" loss of Medicaid benefits when income reaches a specified level—the so-called "notch" problem—is an unacceptable defect in the current structure of Medicaid.

The National Council has been all too aware of this "unacceptable defect" and urges immediate corrective action. I introduce for the record a report by one of our Senior Aides, detailing three cases of impoverished Social Security recipients whose Medicaid benefits were withdrawn because of the badly-needed 15 percent increase in their cash Social Security benefits.

Also included for the record is our Convention's resolution on Medicaid.

IN CONCLUSION

Reform of the Social Security system is long overdue.

When enacted 35 years ago, our Social Security program was a bold and forward-looking step for a nation in the grips of a gigantic depression. But most of the steps to improve the program over the years have been far from bold. These steps—and the proposed 5 percent increase in benefits is the most recent of a long list of examples—have been aimed primarily at alleviating the all too obvious hardship of a retired population struggling to keep up with the rising cost of living.

Past actions have not attempted to tap the nation's rising productivity or to bring benefits into line with our rising standard of living. They have instead perpetuated the depression philosophy which gave birth to our Social Security program.

As a result, the retirement income crisis in this nation has deepened, as amply demonstrated by the Senate Committee on Aging in the reports on the Economics of Aging published during the last year and a half. And we now have further evidence, in that the number of aged living in poverty actually increased between 1968 and 1969. Poverty in any form is a national disgrace, but it seems particularly disgraceful when the tool for eliminating much of this poverty among the aged—a time-tested Social Security system—is readily at hand.

Over the years, opponents of basic reform of the Social Security system have argued that low income of the aged is a transitional problem, more appropriately handled through public assistance than social insurance. Again, the Senate Committee on Aging has documented that this is *not* a transitional problem—that given present trends, inadequate income will still be a problem plaguing future generations of aged people.

The National Council of Senior Citizens therefore urges this Committee to report out legislation that, through basic reform of the benefit structure and financing of the system, would immediately enable today's retirees to share in the economic abundance they helped to create and at the same time would assure to future retirees—today's workers—an income adequate in relation to their standard of living prior to retirement.

[ATTACHMENT A]

NATIONAL COUNCIL OF SENIOR CITIZENS—1970 CONVENTION RESOLUTIONS RELATING TO SOCIAL CASH BENEFITS, MEDICARE AND MEDICAID

SOCIAL SECURITY CASH BENEFITS

Whereas, since the Eighth Convention of the National Council of Senior Citizens, Social Security benefits have been increased 15%, with a proposal that has passed the House to provide another 5% by January 1, 1971 and

Whereas, the House has voted to raise benefits to widows to 100% and liberalized the earnings test to $2,000 annual earnings before reductions would be introduced, with $1 in benefits withheld for each $2 of earnings in the range of $2,000 up to $3,200,

Whereas, despite this progress, an estimated 5-7 million Social Security recipients still remain impoverished, a situation that can only be remedied by the Gilbert-Williams bill with its proposals for substantially raising minimum benefits and an across-the-board increase of another 35% in Social Security benefits, phasing in of an increase in the wage base up to $15,000, and a contribution from the general revenues that would eventually provide for one-third of the cost of the benefits,

Whereas, the National Council of Senior Citizens deplores the delay in enactment of a 15 per cent increase in retirement benefits for railroad employees to match the 15 per cent Social Security increase voted by Congress last year; now, therefore, be it

Resolved, That this Ninth Convention of the National Council of Senior Citizens hereby expresses its appreciation to the Members of Congress for the action

taken in this 91st Congress with respect to increased benefits and other improvements in Social Security; be it further

Resolved, This Convention considers the 15% increase of January, 1970, and proposed increases as a down payment on those benefits proposed in the Gilbert-Williams bill and reaffirms its support for the Gilbert-Williams bill which provides for a further 35% increase in benefits by 1972 for present and future retirees and utilization of general revenue funds to finance a portion of the cost, thus avoiding undue burden on workers with low incomes.

This Convention supports the inclusion of an automatic cost-of-living adjustment as a principle so long as it is recognized as a matter of public policy that there shall also be adjustments in future benefits to recognize rising productivity and standards of living.

Be it resolved, That the National Council's 2,500,000 membership urges Congress to speed action on the pending 15 per cent railroad pension increase and requests early action to assure parity for railroad employees as and when the Senate acts on the House-approved bill to grant an additional 5 per cent increase in Social Security benefits; be it further

Resolved, That those working under the Railroad Retirement Act, those receiving veterans' pensions, and recipients of Public Assistance shall not be subjected to a reduction in such benefits as the result of the increase in Social Security benefits.

Health Care for All Americans

Whereas, Medicare with its deductibles and co-insurance and other features pays less than half (46%) of all the health care costs of the elderly,

Whereas, Medicare makes no provision for out-of-hospital prescription drugs, eye care, hearing aids, and medically necessary prosthetic applicances, and places sharp limits on hospitalization and nursing home care,

Whereas, health services in the United States, when measured by health indices such as infant mortality, maternal mortality and life expectancy rates are surpassed in at least 15 other countries,

Whereas, in the most advanced industrial country in the world, with a scientific capacity to land a man on the moon, the present fragmented, costly, inefficient and inadequate health care arrangements, can only be characterized as antiquated,

Whereas, many of the chronic ailments and crippling conditions of later life are the result in part of the lack of comprehensive and adequate health services in earlier years; now therefore, be it

Resolved, That this chaotic and expensive state of affairs in health care be replaced by a Federally sponsored, comprehensive national program of health care for all Americans, as represented in H.R. 15779, introduced by Congresswoman Martha Griffiths of Michigan, and as represented by the efforts of the Committee for National Health Insurance under the leadership of the late United Automobile Workers President Walter P. Reuther; be it further

Resolved, That H.R. 15779, which will absorb Medicare, into the National Health program, eliminates deductibles and co-insurance, the monthly premium for Medicare Part B (doctor's insurance), provides out-of-hospital prescription drugs, eye care and hearing aids, and removes limits on hospitalization and nursing home care, be hereby endorsed and supported by this Ninth Convention of the National Council of Senior Citizens; be it further

Resolved, That this Convention register its support for the financing of this health care program through the Social Security system, supplemented by general revenues.

Resolutions on Nursing Home Care—Safety in Nursing Homes

Because of the terrible loss of life which results when fires occur in institutions where patients are confined without ability to ambulate, be it

Resolved, That the National Coulcil of Senior Citizens call on the Federal Government to institute the following minimum fire safety standards:

(1) Medicare's conditions of participation in Extended Care Facilities and Medicaid's standards for skilled nursing homes must be revised to include compliance with the Life Safety Code of the National Fire Protection Association.

(2) The U.S. Department of Commerce should promptly implement the Flam-

mable Fabrics Act and should replace its recommended "pill test" as it relates to carpet and rugs with the UL 723 tunnel test.

(3) Carpeting manufacturers should be ordered to label their products in such a manner as would inform the public of their flammable properties under this tunnel test and should sell only Class A or Class B carpet to nursing homes, hospitals, and schools.

(4) The U.S. Congress must also insist on licensed institutions prohibiting all smoking except in specified areas in hospitals and nursing homes where patients are confined without the ability to ambulate.

Intermediate Care Facilities

Whereas, the provision of services to ailing elderly persons in intermediate care facilities was a major accomplishment of the Social Security Amendments of 1967; and

Whereas, this program was designed to meet a need not covered by Medicare, the Federal program of health insurance for the elderly, nor Medicaid, the Federal-State program of health care for the needy; and

Whereas, many hospitalized individuals reach a condition unlikely to benefit from further hospitalization or care in a skilled nursing home but still requiring services not available in their own homes; and

Whereas, Medicare now makes no provisions for this contingency and there is little indication the program will be adequately developed under Medicaid; now, therefore, be it

Resolved, That Congress make intermediate care facilities eligible for reimbursement under Medicare including transfer agreements with hospitals and extended care facilities on a basis of reasonable cost of the care provided; and be it further

Resolved, That the National Council of Senior Citizens join with Congressman David Pryor (D., Ark.) in protesting the recent action of the Secretary of Health, Education and Welfare in eliminating all Federal requirements governing intermediate care and intermediate care facilities under Medicaid (Federal Register June 10, 1970). Be it further

Resolved, That removal of any and all Federal requirements governing intermediate care and intermediate care facilities under Medicaid endangers the program by making it possible as a money saving device for States to substitute intermediate care for patients in need of skilled nursing care: and be it further

Resolved, That the National Council of Senior Citizens insist upon the Department of Health, Education and Welfare recalling its action of June 10, 1970, and proceeding instead with development of an intermediate care program as the law requires.

Exploitation and Abuse of the Elderly Sick

Whereas, the National Council of Senior Citizens is deeply committed to assuring that the highest standard of care shall be afforded the one million of our fellow seniors who are in nursing homes, financed under the Medicare, Medicaid, and other programs,

Whereas, there is mounting and deeply distressing evidence that in too many nursing homes, elderly people are neglected, treated with indignity, receiving minimal, if any, health care,

Whereas, the many State and Federal agencies, including the Department of Health, Education, and Welfare, and State Health and Welfare departments, have failed to secure the appropriations required, or to exercise the aggressive leadership required to enforce standards of safety, health, and general welfare of residents, with the result that too many elderly persons have been neglected, and the payments for their care misused,

Whereas, as a result in part of the failure of governmental authorities to enforce standards, commercial operators, looking for quick returns on their investments, have invaded the nursing home field by establishing what amounts to chains of motels insufficiently concerned with the health and welfare of the residents in their charge, and have succeeded in converting nursing home programs into housing programs instead of health programs, and have imposed upon elderly people who are sick a "buyer must beware" philosophy: be it

Resolved, The National Council of Senior Citizens hereby salutes Congressman David Pryor of Arkansas, who, by working as a volunteer in the Washington area nursing homes, exposed the extent to which many older people are dehumanized in many nursing homes in the "thirsty quest for big profits," and further, the lack of leadership and cooperation of the government bodies with respect to protecting the sick elderly.

Resolved, That the National Council of Senior Citizens endorses the resolution introduced by Congressman Pryor, calling for the establishment of a select committee on nursing homes and homes for the aged, charged with studying a wide range of Federal programs concerned with nursing care, viz. HEW, through Medicaid, Medicare, and the Public Health Services, the Mortgage Insurance Program of the Housing and Urban Development Agency, the Loan Program of the Small Business Administration, and the responsibilities of the Securities and Exchange Commission for the supervision of corporations issuing stock for nursing home operations; be it further

Resolved, That a substantial increase in direct grants and loans be made to non-profit and governmentally operated nursing homes, with a five-year goal of providing 50% of the homes under non-profit suspices; be it further

Resolved, That substantial funds be provided for alternative methods of care—foster homes, sheltered low-cost supervised housing, and day care centers,

Resolved, That the National Council of Senior Citizens, through its affiliated clubs, develop a program of citizen review teams in which responsibility for periodic inspection and visiting of nursing homes in the clubs' areas would be vested.

MEDICARE

Whereas, the National Council of Senior Citizens views with pride and satisfaction the significant role it played in the enactment of Medicare,

Whereas, a series of financial barriers, co-insurance, deductibles, premium payments for Medicare Part B (Doctor insurance—scheduled on July 1st to go from $4.00 a month to $5.30), and non-coverage of out-of-hospital drugs, continue to limit and deny adequate health protection to the elderly,

Whereas, escalating costs and evidence of overcharging and abuses of the program call for effective cost controls and penalties that do not, however, limit the services or penalize the patient,

Whereas, the option provided under the House-passed Social Security bill, H.R. 17750, would enable Medicare recipients to participate in prepayment health plans which provide both preventive as well as maintenance health care services at lower cost than the present disorganized health system; now, therefore, be it

Resolved, That this Convention holds that the co-insurance and deductible features of Medicare and the monthly payment for Part B must be eliminated; and that the added cost be met by contributions from general revenues, and further, this Convention supports the elimination of the three-year enrollment period for Part B of Medicare and Congressional action to limit physicians' charges to a reasonable amount; be it further

Resolved, That the cost of prescription drugs, eye care, eyeglasses, dental care, dentures, hearing aids, and routine foot care be included in Medicare, and that hospital coverage be extended to 365 days; be it further

Resolved, That the National Council support and promote the enrollment of seniors in pre-payment health care plans and the further and substantial development of such plans; be it further

Resolved, That all persons receiving Social Security benefits be included under the Medicare program.

MEDICAID

Whereas, Medicaid was designed to serve the millions of Americans, particularly those under 65 whose income was so low they could not afford the costs of medical care,

Whereas, the original legislation obligated all States to develop a program of comprehensive services by 1975—later extended to 1977, and now completely abolished in the pending Social Security bill, H.R. 17550, on the argument that costs were sky-rocketing and the program was being exploited by practitioners—a product in part of inadequate medical surveillance.

Whereas, various restrictions are being placed on Medicaid, including granting the States the right to impose deductibles, thus still further cutting back on the intent of the original legislation; now, therefore, be it

Resolved, That this Convention reaffirm its support of Medicaid as an essential program to meet the costs of health care of persons with low income, and urge that the provision requiring States to develop a comprehensive program not be stricken; be it further

Resolved, That until a program of National Health Insurance is established and adequately financed, the Medicaid program is essential to the well being of millions of Americans living on the borderline of income adequacy; be it further

Resolved, That the Federal Government establish firmer controls over medical charges and utilization to stop exploitation of the program.

[ATTACHMENT B]

THREE CASE REPORTS ON "SUDDEN DEATH"—LOSS OF MEDICAID BENEFITS WHEN SOCIAL SECURITY BENEFITS WERE INCREASED

(Reported by David Caple, Senior Aide, Project Involve, Milwaukee, Wis.)

I am writing to call your attention to the plight of the elderly citizens who have received the 15% increase in their monthly benefits. To introduce myself, I am a Senior Aide with Project Involve, doing "Following Work." It is my duty to answer complaints and try to remedy them. Since receiving this increase in income, these people are having their Title 19 cards cancelled. The maximum income a person can have is $133.00 per month to obtain a Title 19 card. I guess you are aware of this, and these are the people whose income was just below that figure, and now, their income is above that figure. So you can see, the increase isn't helping them at all.

Allow me to cite some of the cases I have encountered recently. Mrs. X who lives in a public housing pays $40.00 per month for rent. She is practically deaf. Has to use a hearing aid which she is paying for at the present time. She uses 12 batteries per month at a cost of $5.52. Her hands are drawn into fists from Arthritis, she has to buy various medicines for that. She also has swollen legs. I don't know the cause. The W.M.A.P. cancelled her card but I put these facts before them and they renewed it.

Mrs. Y also lived in public housing paying $40.00 per month. She had a stroke recently and also a heart condition. I was carrying her to her doctor at intervals for a foot ailment. She was using about five different kinds of prescription medicine which she said she had to have daily. Because of the Social Security increase they cancelled her Title 19 card and she was wondering how she could continue with her medicine as it was quite expensive. I had an appointment to carry her to her doctor Monday July 27. I called her repeatedly that morning but got no answer, later I went to the apartment manager and told her the situation. She accompanied me to the client's apartment and we discovered the cause—she was dead.

Mrs. Z is a wheel-chair patient, not able to walk or stand. A victim of Multiple Sclerosis, she has an income of $153.80, since the increase. She pays $95.00 per month for rent, has to pay a neighbor $15.00 per month to do chores for her, beside a utility bill about $15.00 and numerous medical bills. Her card was cancelled.

They call me for an answer. I am not able to furnish one. I go to the medical center, tell them the facts. Show them my data sheets. They tell me to bring in enough medical bills to cover the surplus income. That I cannot do, since their bills were being paid with their Title 19 card.

Sir, it is quite an ordeal when I have to go to these people and tell them that I can't help them. I have put these cases before you in the best manner I am capable of, and these are just a few. I hope something can be done.

The CHAIRMAN. Thank you very much for a very good statement. That concludes, then, this morning's hearing. The committee will stand in recess until 2:30, at which time we will commence with Mr. Paul Henkel.

(Whereupon, at 12:40 p.m., the committee recessed, to reconvene at 2:30 p.m., this same day.)

AFTERNOON SESSION

The CHAIRMAN. The next witness will be Mr. Paul P. Henkel, chairman of the social security committee of the Council of State Chambers of Commerce.

STATEMENT OF PAUL P. HENKEL, CHAIRMAN, SOCIAL SECURITY COMMITTEE, COUNCIL OF STATE CHAMBERS OF COMMERCE; ACCOMPANIED BY WILLIAM R. BROWN, ASSOCIATE RESEARCH DIRECTOR OF THE COUNCIL

Mr. HENKEL. Good afternoon, Mr. Chairman. Thank you for the opportunity to appear at this hearing to present our views.

For purposes of the record, I am Paul Henkel, manager of payroll taxes of the Union Carbide Corp. I am appearing as chairman of the social security committee of the Council of State Chambers of Commerce.

With me is Mr. William R. Brown, the associate research director of the council.

Mr. Chairman, we request that our lengthy prepared statement with respect to H.R. 17550 be accepted for the public record.

The CHAIRMAN. That will be done.

Mr. HENKEL. We have outlined in our prepared statement our continuing and underlying concerns about social security. We believe this committee is well aware of those concerns because we have stated them many times.

Currently, we are indicating our support for a 5-percent across-the-board increase, not because we feel that Congress has lagged in raising benefits, but because we feel that the increase anticipates potential increases in the cost of living for our current social security beneficiaries.

We would point out that we had supported a 10-percent increase in benefits as recently as November 1969. But the fact that Congress enacted a 15-percent increase at the beginning of the year is not going to be used by us to oppose this 5-percent increase.

We have indicated in our statement our support for a liberalized retirement earnings test. We do not support, however, the House-passed version of this liberalization. We believe that there should be a 50-cent reduction in social security benefits for each dollar of annual earnings between $2,000 and $3,200, and a dollar-for-dollar reduction in benefits for each dollar of annual earnings in excess of $3,200. This would be similar to the pattern of past changes that have occurred in connection with this particular provision.

We oppose section 114(a) of H.R. 17550 which would raise the ceiling on combined workmen's compensation insurance and social security benefits. This section could permit a disabled person to receive more in tax-free benefits than his prior after-tax earnings. Our prepared statement includes an appendix and several examples displaying these results.

We note that the Social Security Administration, itself, has some reservations about this provision.

We object to the proposed $9,000 taxable wage base because we believe it is not needed even to finance a 5-percent benefit increase.

We think that the old age insurance program has been overfunded since 1966, and will continue to be overfunded. Yet, the $9,000 taxable wage base will cause the Old Age Insurance Trust Fund to increase $6.2 billion by 1974, and then the 1975 scheduled tax rate increase will cause the fund to increase by $10.4 billion in 1 year.

What concerns us is the long-range estimate that even with a $9,000 fixed taxable wage base the old age insurance trust fund balance in the year 2025 could decline from an amount of $240 billion to a zero balance in the year 2035. We interpret this to mean that, even with a slight modification which is projected and proposed now, there would be an annual requirement of $24 billion over a 10-year period which would have to come from either Federal general revenues or additional payroll taxes over and above those that are already required.

But if the Congress, nevertheless, decides that additional tax revenue is needed at this time, we strongly urge consideration of alternatives, higher tax rates or taxable wage base of $8,400, rather than $9,000, alternatives which apparently have been disregarded.

We have, with the aid of actuaries, computed that the equivalent in the social security tax increases under the proposed $9,000 taxable wage base could buy a private annuity which would be $20.88 a month more than the increased monthly social security benefits, this for a youngster who is aged 26 in 1970 and who would have had maximum taxable earnings.

Because of this, we raise the question whether Congress can be assured of the continued popularity of the social security program among the young people. We suggest that it might be well to reconsider whether it is appropriate to continually mandate the sequestration of a greater amount of the otherwise disposable income of the present young in future generations.

We object most strenuously to the enactment of the automatic escalators in the taxable wage base, in the benefits and retirement earnings test. We feel these proposals eliminate from consideration general economic conditions at any given time in the future. We think the proposals will have inflationary effects.

We are appalled by the now published estimates of how the taxable wage base will rise to $22,000 in 1992. We have included in our table III of our prepared statement, which indicates that there may not be any, or little, correlation between the automatic escalator of the taxable wage base and the automatic escalator for the benefits. We think this could lead to a serious dislocation in the financing of the program and could require more, not less, attention from the Congress.

We have included tables IV and V and chart III in our prepared statement which portray how an inordinate amount of the future social security tax burden could be shifted from middle and higher income social security taxpayers. We object to this because the automatic escalation seems to foreclose further consideration of the future of tax rate increases.

We have shown on table VI in our prepared statement the staggering increases in tax costs which could occur if automatic escalation is enacted.

Under maximum annual tax figures, we have compared these costs both under the present law, under a fixed $9,000 taxable wage base, and under an escalating wage base, which is in line with the official estimates.

The highlights of the table show that, first, under the present law, a person aged 64, in 1970, will have paid $3,800 in taxes for his benefit coverage. But those who are under age 16, in 1970, could pay as much as $20,000 in social security tax for their benefit coverage.

Second, if the $9,000 taxable wage base is enacted and remains fixed, those under age 16, in 1970, could pay almost $26,000 instead of $20,000 in tax. There would be a 27-percent increase in tax for a 12-percent increase in benefits.

Third, under the escalating wage base a 1-year-old in 1970 could pay $62,500 in tax over his entire career. This is $42,300 more or 208 percent more, than he would pay under the present law.

We have been vitally concerned that the relationship between the social security benefit formula and the tax costs shows a diminishing return on the investment as the individual's career taxable earnings increase. This condition could accelerate under automatic escalation if the benefits are raised 3 percent a year and if the taxable wage base is increased by 5.2 percent a year, as past history has demonstrated.

In table VIII of our prepared statement we have related the maximum social security tax costs to potential lifetime primary insurance amount benefits. For the tax costs we have used an accumulation of 77 percent of the combined employer-employee OASDI tax on the theory that the remaining 23 percent applies to survivor and dependency benefits.

We think that the data shows that today's younger workers and those yet to join the labor force are disadvantaged in comparison to today's retirees. The younger ones can be certain that under automatic escalation their social security tax could triple. But we question whether or not they can be assured that their return in benefits will be increased commensurately.

We have mentioned in our prepared statement that employers are greatly disturbed about the prospective tripling of the employer social security tax costs which would occur under automative escalation. These tax costs will only make it more difficult to do business in the future, and probably will be reflected in future price levels.

We have pointed out, too, that the employer's social security tax has become the largest single element and the most expensive element of the average employer's fringe benefit costs. In the last 10 years this element has increased 200 percent or four times faster than the increase in average wages.

In the same period, the average employer's private pension plan cost has increased only 61 percent as compared to 200 percent. This is the reason for the already existing apprehension among employers that an excessively liberal social security program can lead to the elimination of private pension plans. We believe the automatic escalation in both taxes and benefits would apply too broadly.

We suggest that there be continual periodic review by the Congress of the social security program. This has been an actuality since 1965. We suggest that priority be given to the matter of increasing benefits periodically, and that less attention be given to the problems of expanding coverage and providing new classes of beneficiaries and liberalizing eligibility conditions.

Finally, we urge the Congress to be mindful of the unavoidable thrust and impact of some form of universal health insurance pro-

gram. It is our judgment that each passing year brings us nearer to the adoption of some program which, in all probability will utilize the payroll tax mechanism in whole or in part.

Preliminary estimates indicate that such universal health insurance coverage would be a staggering additional load to place upon the payroll tax, whether or not it is passed on to the consumer in the form of higher prices.

The current, the highest preliminary estimate is $50 billion a year.

In closing, we ask this committee to enact the 5-percent benefit increase and to liberalize the retirement earnings test, which we have suggested, and to change the financing of the social security program, but only to the extent it is absolutely necessary.

We urge most strenuously that you reject the proposed automatic escalators.

Thank you, sir.

(The prepared statement of Mr. Henkel follows. Hearing continues on page 876.)

Statement of Paul P. Henkel on Behalf of Member State Chambers of the Council of State Chambers of Commerce

SUMMARY

1. *Recognize the need to increase Social Security benefits* to compensate for the increased cost-of-living, but oppose the automatic cost-of-living escalator. There is no substitute for periodic Congressional review of benefits and financing, at the same time taking all pertinent factors into consideration, not just those that may be in an automatic formula.

2. *Support periodic review and adjustment of retirement test* in light of changing economic conditions, but oppose automatic adjustment of the exempt earnings level. Support the Ways and Means Committee proposal to increase the annual amount of exempt earnings an individual may earn and still get full benefits from $1680 to $2000, but oppose the amendment added on the House floor which would further exempt earnings beyond $2000.

3. *Support periodic Congressional review of financing.* Tax rates and the wage base need to be considered together in light of current and short term benefit costs, not just in relation to changes in wage levels, and higher benefit costs should be met primarily by raising tax rates rather than the tax base; therefore, we strongly oppose the proposed automatic increase in the taxable wage base. If Congress does not enact the proposed automatic cost-of-living increase proposal, there is no need for the automatic tax base increase proposal.

4. *Oppose change in Workmen's Compensation offset* which would permit combined compensation and social security disability benefits to exceed 100% of average current earnings before disability instead of the present 80%. This would result in benefits greater than former take-home pay and eliminate the monetary incentive for rehabilitation and employment.

STATEMENT

Mr. Chairman and Members of the Senate Finance Committee: My name is Paul Henkel and I am Manager of Payroll Taxes for Union Carbide Corporation. I am Chairman of the Social Security Committee of the Council of State Chambers of Commerce and I am appearing on behalf of the member State Chambers of Commerce of the Council which are listed at the end of this statement as having endorsed our statement. Accompanying me is Mr. William R. Brown, Associate Research Director of the Council.

We appear before the Senate Finance Committee to reiterate the views of the Council of State Chambers of Commerce on current social security proposals. These views were stated at the House Ways and Means Committee hearings last November on H.R. 14081. We are pleased to lend support to a few of the proposals in H.R. 17550 which supplants H.R. 14081.

Our continuing underlying concerns in the matter of social security are severalfold. We seek sound financing without excessive current taxation. We seek to

have our citizens, particularly the young people, understand the staggering costs of the program that can occur within two or three generations because of seemingly modest benefit increases enacted currently. We seek to reverse the growing disregard of actuarial principles in favor of considerations of need, expediency and political motivation in expanding the social security program. We seek a halt in the continual shift of the social security tax burden to middle income groups and to the structuring of the benefit formula to the greater advantage of the group earning less than the maximum taxable wage.

We seek to eliminate the ever present and mounting danger that the social security program will be transformed from a program providing a minimum floor of protection into a program that will ultimately dominate, control and even eliminate private industrial retirement programs. This can occur through excessive expansion in benefits and tax costs of the social security program.

Our concern has been given new emphasis by the published views of the recently resigned Chief Actuary of the Social Security Administration, Mr. Robert J. Myers. It seems that we have had grounds to be apprehensive concerning the motivation of the planners in the Department of Health, Education, and Welfare.

SUPPORT FOR A 5 PERCENT BENEFIT INCREASE IN 1971

Last November, we supported the 10% increase in benefits proposed in H.R. 14081. That bill also contained many of the proposals that are now included in the present H.R. 17550. Congress enacted a 15% increase in benefits as part of the Tax Reform Act of 1969. Now, on the basis of the recent acceleration in the Consumer Price Index, H.R. 17550 proposes a further 5% increase in benefits effective January 1, 1971. We do not oppose this increase—in fact we support it.

In doing so, we would point out this would be the third across-the-board increase since February 1968 and the eighth such increase since 1950. Attached as Table I and Chart I are an outline and a chart respectively of changes in the primary insurance amount. We think they show two things—first, that the Congress may have lagged in raising benefits only during the period 1958 to 1965; and second, that the benefit formula continues to discriminate against the higher income social security retiree. Table II demonstrates that with the proposed change in the benefit formula the primary insurance amount will be 85% of the first $110 of the average monthly wage but will be only 37.8% of an average monthly wage of $750. We think this aspect should receive more attention and correction.

Whenever the Congress considers a social security benefit increase, there are constant and strident allegations raised that the current beneficiaries are in dire circumstances. We concede that our current beneficiaries are particularly vulnerable and consequently apprehensive concerning the erosion of their real income because of spiraling costs and prices. But we disagree with these allegations and believe they have been over-accentuated and over-dramatized for political reasons. A more objective perspective is needed.

In relating increases the 1957–1959 Consumer Price Index (CPI) to the trend of the maximum and average monthly primary insurance amount up to the end of 1969 (before the 15% increase effective in January 1970), it will be found that:

[In percent]

	CPI	Increase in maximum monthly PIA	Average monthly PIA
1940 to 1970	+166	+301	+340
1950 to 1970	+55	+265	+126
1960 to 1970	+26	+39	+34
1965 to 1970	+18	+34	+18

It is significant to note, too, that Chairman Wilbur Mills of the House Ways and Means Committe has pointed out that in the past the social security benefits have been raised by Congressional action much more than if a 3% automatic escalator in benefits had been in effect.[1]

[1] Page H 4669—Congressional Record May 21, 1970.

In light of past performance, we do not think the Congress has been remiss in raising benefits. As a corollary to this, we disagree most emphatically with the contention that an automatic escalator in benefits is justified because of alleged lack of Congressional action. Our objections to the automatic escalator in benefits are set forth later in our statement.

SUPPORT FOR A LIBERALIZED RETIREMENT EARNINGS TEST

We indicated in our testimony on H.R. 14081 before the House Ways and Means Committee that we would support an increase of exempt retirement earnings from $1680 to $1800 per year, an extension of the present reduction of $1.00 in benefits for each $2.00 of earnings up to $3000 instead of $2880, and a continuation of the $1.00 reduction in benefits for each $1.00 of earnings in excess of $3000. This would be consistent with the past history and pattern of changes in this offset provision.

We support, now, Section 106(a) of the version of H.R. 17550 reported by the House Ways and Means Committee. That section provided an increase in the 50% reduction of benefits for earnings between $2000 and $3200 and a continuation of the 100% reduction for earnings in excess of $3200.

We object to the application of an automatic escalator to the retirement earnings test. Our reasons therefor are included later in our statement.

OPPOSITION TO INCREASE OF WIDOWS' AND DEPENDENT WIDOWERS' BENEFITS

Under the present law, a widow receives 82½% of the benefit amount her husband would have received if he began receiving benefits at or after age 65. The 82½% was increased from 75% in 1961. Section 103 of H.R. 17550 proposes to increase the percentage to 100%.

The point was made both in Ways and Means Committee Report No. 91–1096 and in the statement of HEW Secretary Richardson presented to this Committee on July 14, 1970, that widows have less regular income than most other beneficiaries and, in general, are financially worse off. While this point may be valid, we question whether it is appropriate in relation to a wage-related insurance program. A further point is made that a widow should not be expected to live on less than her husband would have been paid if he had lived.

We submit in reply to these two points that the Congress has since the inception of the social security program maintained the concept that a retired couple should receive 150% of a primary insurance amount. This concept stemmed from a popular objective in private insurance annuities and pensions where the survivor generally receives 50% of the prior combined benefit (or 75% of the primary benefit). Alternatives and variations are of course permitted in joint and survivor benefits under private annuities, but they are often more expensive and require greater premiums. This is, of course, overlooked or minimized by social security planners.

The current proposal is expensive—it has a first year cost of $700 million benefiting 3.3 million widows and dependent widowers—it has an estimated level cost of 24/100ths percent of taxable payrolls and it is twice the amount of the 12/100ths percent actuarial imbalance of the OASI system.[2] It would increase the estimated level cost of widows' and widowers' benefits from 1.3% to 1.54% of taxable payrolls—an 18% increase in such costs.[3] We urge, therefore, that the Committee reject the proposal to increase widows' and dependent widowers' benefits.

OPPOSITION TO AGE 62 CLOSING DATE FOR MEN

Section 104 of H.R. 17550 proposes to change the closing date in the primary insurance amount (PIA) computation to the year in which a man attains age 62. Currently, the closing date for a man is the year in which he attains age 65. However, the closing date for a woman already is the year in which she attains age 62. This latter provision was made in the 1960 amendments to the Social Security Act, and was recently held as constitutional and not discriminatory against men.[4] Regardless of the reasoning underlying the 1960 enactment, or the judicial decision, or the proposed Constitutional Amendment concerning discrimination on the basis of sex, we have never agreed with the principle that

[2] Page 78, House Report No. 91–1096.
[3] Page 79, House Report No. 91–1096.
[4] Oskar Gruenwald v. John W. Gardner, 390 F2d 591

there should be an earlier closing date for women. We think it was wrong, and we think the current proposal is also wrong. Consequently, we oppose it.

We would point out a curious situation. Last year when the House Ways and Means Committee held public hearings on H.R. 14081 (the predecessor bill of H.R. 17550), the Social Security Administration estimated that the "age 62 male closing date" provision would affect 5 million current beneficiaries and 100 thousand new beneficiaries with a first year annualized cost of $392 million. Now, less than a year later, it is estimated[5] that the provision would affect 10.2 million current beneficiaries and 60 thousand new beneficiaries with a first year annualized cost of $925 million. We think this half a billion dollar difference warrants further investigation.

OPPOSITION TO CHANGE IN WORKMEN'S COMPENSATION OFFSET AGAINST SOCIAL SECURITY

We urge this Committee to delete Section 114(a) of H.R. 17550 which would amend paragraph (5) of Section 2249(a) of the Social Security Act. The latter section presently provides that social security disability benefits will be reduced only by the amount by which the combined workmen's compensation and social security benefits exceed 80% of workers' average current earnings before disability. The proposal would increase the percentage from 80% to 100%.

Historically, we have taken the position that an employable individual should receive tax-free benefits from one or more public programs which should be lower than his prior after-tax earnings on which such benefits are based. We reason that there must be an incentive to be gainfully employed. (This is one of the major trusts of the proposed Family Assistance Plan.) We believe this is a reasonable view. We believe, too, that the present law partially coincides with this view. Eighty percent of average current earnings is a fair estimate of after-tax earnings—considering Federal income and social security tax deductions only. Tax-free benefits for not working equal to prior after-tax earnings provide no incentive for gainful employment. To raise the percentage to 100% as is contemplated, could give a disabled worker a 25% premium—a 25% increase over his former take-home pay. This is even less of an incentive for him to seek rehabilitation, retraining, and reemployment.

We cannot subscribe to reasons advanced in the Ways and Means Committee report in support of this change:

(1) The argument that workmen's compensation is, in part, compensation for pain and loss of function is contrary to the underlying theories and concepts of workmen's compensation. The common law concept of compensating for pain is not and never was a part of workmen's compnesation as a social insurance program. Therefore, it is not proper to use this as argument in favor of tax-free benefits exceeding after-tax wages.

(2) The point that "a worker's total disability will usually give rise to substantial expenses in addition to the family's continuing regular expenditures" overlooks the fact that virtually all states now pay all medical expenses as well as related transportation costs for medical treatment. Also the full cost of rehabilitation programs is assumed in many jurisdictions.

(3) In evaluating the impact on a family's standard of living, the fact that the disabled worker is relieved of many of the expenses normally incident to working, such as transportation, meals, clothing, union assessments, etc., should be considered. Also, there are other benefits for the totally and permanently disabled, private hospitalization and medical insurance, income tax medical deductions, private disability insurance, industry disability benefit plans and rehabilitation services, all of which can and do mitigate financial hardships.

We have attached an eight-page Appendix A which is a series of examples developed by James S. Stickles, a Workmen's Compensation Specialist for the American Mutual Insurance Alliance. The examples demonstrate how the proposed Section 114(a) of H.R. 17550 would provide tax-free benefits for disability in excess of after-tax earnings before disability.

We would point out the reservations of Social Security Commissioner Robert M. Ball expressed to this Committee on last July 14 about increasing the limit of combined workmen's compensation and social security disability benefits. We do not concur fully with his position, however, that this matter should be studied by the Social Security Advisory Council. We believe the present 80% limit should be retained.

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[5] Page 16, House Report 91-1096.

OPPOSITION TO A $9,000 TAXABLE WAGE BASE—ALTERNATIVELY, SUPPORT FOR TAX RATE INCREASES

On the basis of current information we fail to see, and current official data fails to demonstrate, why a further 5% increase in benefits proposed in H.R. 17550 requires a $9000 taxable wage base at this time. The official data available in November 1969 indicated that the 10% benefit increase would not require additional financing. This confirmed our belief that the system has been over financed since 1966. We still suspect that this situation may exist.

We would point out that House Report 91–1096 indicates that H.R. 17550 would produce a greater allocation of contribution income to the Hospital Insurance Trust Fund (in order to cure its underfinanced status) and, in addition would produce through 1974 a cumulative excess of $6.2 billion in the Old Age Insurance Trust Fund.[6]

Furthermore, in 1975 and the years immediately following, when the old age insurance tax rate jumps from 4.2 to 5%, the Old Age Insurance Trust Fund balance will jump by ***$10.4 billion*** in one year.

House Report 91–1096 also indicates the following growth in the combined Old Age Insurance and Disability Trust Funds:[7]

[In billions of dollars]

	Taxes	Benefits	Fund balances
1980	57.6	49.3	83.4
1990	65.0	65.1	165.6
2000	98.6	126.2	285.9
2040	113.2	146.9	46.6

Despite the huge balances in the trust funds in the year 2025, the Old Age Insurance Trust Fund will be exhausted by the year 2035 (10 years later) because of the current small actuarial imbalance (a minus .12% in the level premium costs of the program). We interpret this to require a $240 billion charge against Federal general revenues or additional payroll taxes during that remote 10 year period. This is $24 billion a year!

We ask you to bear in mind that these actuarial projections are based on the $9000 taxable wage base and schedule of tax rates as approved by the House Ways and Means Committee in May of this year. They were also based on the use of favorably adjusted factors—higher interest rates, higher male and female labor force participation, etc.[8] These factors are highly speculative and conjectural. The projections are cogent, relevant, and highly persuasive to the conclusion that the future of the system is assured. But we do not share this assurance or optimism that the system will be as popular and as beneficial to each successive generation as it is to the present old and mature generations.

We reiterate our longstanding position that the social security tax rates should be raised before the taxable wage base is raised. We believe that everyone, including low income groups, should bear some of the increase in tax costs that provide higher benefits. We do not share the alarm of some who argue that the social security tax is regressive—we feel this argument simply is offered as a basis for imposing increased taxes on middle income groups who in the final analysis get proportionately lower benefits than do the low income groups.

There is no published information and we suggest that this Committee investigate what the situation would be if the 1971 tax rate were to be raised above 5.2%, or if the taxable wage base were to be raised to $8400 instead of $9000, or if the taxable wage base were to be raised to $8400 and the tax rates were to be increased above 4.8% but less than 5.2%. We are being asked to accede to the current proposals on the basis of incomplete information furnished by HEW. We do not think that HEW or the Administration has "made its case" that the $9000 taxable wage base is unavoidable and mutually exclusive of other alternatives. To be fashionable—we protest. We have had a $7800 taxable wage base for two years. What's wrong with having a $8400 taxable wage

[6] Pages 79–80, House Report 91–1096.
[7] Page 82, House Report 91–1096.
[8] Page 77, House Report 91–1096.

base for at least two years (1971–1972) whether or not coupled with a tax rate increase? Whatever happened to the $600 incremental increase in the wage base we used to have during the fifties? We think it is appropriate for Congress to sample the opinion of the middle income and higher income groups as to whether they think the prospective social security tax increases are commensurate with the prospective social security benefit increases.

THE EQUIVALENT IN INCREASED SOCIAL SECURITY TAXES COULD BUY A BETTER PRIVATE ANNUITY

As we did in connection with the 1967 Social Security Act Amendments, we have again made a comparison, with the aid of private insurance actuaries, of the value of the increased cost to an individual of increased social security benefits or an equivalent private retirement annuity.

We assumed an employee age 26 in 1967 paid the maximum tax during his career until he became eligible for the maximum monthly benefit (PIA) at age 65 as of January 1, 2006. We doubled the accumulated increase in taxes caused by the proposed $9000 taxable wage base in 1971. The doubling represents the combined employer-employee tax. We accumulated 72% of this doubled amount—the difference, 28%, being considered by HEW to be attributable to survivorship and disability protection.

We found that the increased tax would accumulate to $4383.94. This will provide an increased social security benefit in the year 2006 of $32.30 per month; and a lifetime amount over a 15-year life expectancy of $5814.00. The same $4383.94 would provide an equivalent private lifetime annuity of $53.18 per month ($20.88 per month more than social security) and a lifetime amount over a 15 year life expectancy of $9561.60.

We know that HEW disputes our approach and makes similar comparisons on the basis of accumulated employee taxes only. We think our approach is more realistic and is equally, if not more, justified for the reason that an employee looks upon the employer-paid social security tax as a purchase of a fringe benefit for *himself*, not for someone else.

Whether or not our approach is accepted, we think it is time for this Committee and the Congress to assess the attitudes of the young workers—not the academicians, technicians and non-working students—concerning the future tax burden they will be forced to assume. After all, this Congress will be sequestering a greater amount of their otherwise disposable future income without their consent or approval. We suspect that social security taxation is becoming exceedingly unpopular among the young workers.

THE CASE AGAINST AUTOMATIC ESCALATION IN SOCIAL SECURITY TAXABLE WAGE BASE, BENEFITS, AND RETIREMENT EARNINGS OFFSET

We strongly object to the proposals in H.R. 17550 to introduce automatic escalators for the taxable wage base, the benefit schedule and the retirement earnings test. We disagree with the allegation that the proposals would depoliticize the matter of benefit increases. (We already have stated our preference for continual Congressional review.)

The effect of adopting new and additional factors of cost-of-living indices and expansion of wage and coverage will necessarily complicate the actuarial techniques and conceivably could alter the long-term results. We do not think these factors are necessary or desirable.

The proposals would eliminate from consideration the underlying coverage, demographic, and economic factors necessary to determine the actual soundness of the program. They would also eliminate from consideration the general economic climate of the nation as well as the overall burden on our taxpayers.

We do not think it possible to design an automatic formula to meet our objections or avoid the pitfalls mentioned above. We feel that there is no substitute for periodic Congressional review of benefits and financing at the same time.

The inflationary effect of automatic escalators

The proposal to enact automatic escalators for both benefits and taxable wages could have an inflationary effect on the whole of our economy. The escalator for wages could produce substantial excess social security tax revenue which would be used for more Government spending. That spending, with its multiplier of two or three, could expand bank reserves and credit. The greater amount of money in circulation could increase the demand for goods and services

and provide an upward thrust on prices. The escalator for benefits could have a similar effect on demand and prices.

Some would argue that any excessive taxation would have an anti-inflationary effect in that it would reduce disposable income. But this would not hold true because the Government would return the excess to the private sector for further spending. The argument that the disposable income of social security taxpayers should be reduced can hardly find popular support.

Although social security beneficiaries do require special attention for protection against inflation, the adoption of an automatic benefit escalator could weaken their concern for and their will to support anti-inflationary policies. Similar protection could be sought by everybody else in the productive segment of our economy. The automatic benefit escalator in the social security program could be precedent-setting for adoption in private industrial pension plans. These are disadvantageous consequences.

The velocity of increases in the taxable wage base—reliability of estimates

The proposal to automatically increase the taxable wage base relates a $9000 base in 1971 to the ratio of first calendar quarter taxable payrolls in odd-numbered years to 1971. Ostensibly, this seems reasonable.

The Social Security Administration has estimated how the taxable wage base could increase to $22,000 in 1993. (See Page 92 of House Report 91-1096) They are reflected on the graph displayed in Chart II—they are virtually a straight-line projection. The Social Security Administration apparently works with other and different estimates. For example, it advised the Council of State Chambers of Commerce on July 17, 1970, that the taxable wage base could be different:

	H. Rept. 91-1096	SSA estimate July 17, 1970
1973	$10,200	$9,600
1975	10,800	10,200
1977	12,000	11,400
1979	13,200	12,000

The assumptions underlying the projected increases in earnings in House Report 91-1096 were not stated. The July 17, 1970, estimates were based on the following assumed increases in earnings: 5.0% in 1972, 4.6% in 1973, 4.3% in 1974, 4.1% in 1975, and 4.0% thereafter. A question can be raised as to which set of estimates is the most appropriate? A further question can be raised as to why it is valid to assume that the annual increase in earnings after 1976 can be held to 4% per year if the current inflationary forces cannot be controlled.

There is set forth in Table III the past trend of the average quarterly social security taxable wage for the first calendar quarter of odd-numbered years since 1955. This is similiar to the factor which would be used biennially with the proposed $9000 taxable wage base to increase that base in the future. The past trend has been related to the past changes in the maximum annual taxable wage base. The past trend also has been related to a "1957-1959" Index of 100 comparable to the current Consumer Price Index on which the proposed 3% automatic escalator in social security benefits is based.

The wage factor (the biennial percentage increase) increased an average of 5.2% per year—or 10.4% biennially—since 1955. When related to a 1957-1959 Index—the basis of automatic benefit increases—the wage factor increased an average of 5.8% per year or 11.6% biennially. Comparing 1969 to 1967 when the taxable wage base increased from $6600 to $7800, the wage factor increased 12.7% on a biennial basis!

With $9000 as a starting base, a wage factor of merely a 6.6% biennial increase would be necessary to raise the base $600. Yet, past history indicates the biennial increase wage factor averaged between 10.4% and 11.6% for a decade and a decade and a half, respectively. Seemingly this insures a $1200 taxable wage base increase every two years. A closer examination of Table III will indicate that successive increases in the maximum taxable wage base provided a "built-in" or "self-breeding" increase in the factor proposed in H.R. 17550.

The upward spiral in the future taxable wage base seems assured also by the fact that the proposal provides for a plateau but no downward trend.

As startling as the Social Security Administration estimates are, they conceivably could be understated!

The lack of coordination between escalators in benefits and the taxable wage base can produce serious financial dislocation

Proponents of automatic escalation have argued that it would eliminate the need for Congressional review and attention. It is submitted that the social security program will not operate automatically because of the dissimilar nature and inevitably dissimilar operation of the "indicators." It is further submitted that the reverse situation—more attention by Congress—is more probable. We believe that the data in Table II demonstrates that under automatic escalation there is no correlation between the taxable wage and benefit escalators. Table II also demonstrates that there is the likelihood that the taxable wage escalator will rise faster than the benefit escalator. Benefits might have to be increased faster in times of inflation or might have to be held level, or even cut back, if the benefit escalator functions in disproportionate velocity to the function of the taxable wage base escalator. Similarly, the latter escalator might have to be curtailed to prevent embarrassingly excess tax revenue or speeded up to cover current benefit costs. In any event, the long-established custom of determining "actuarial soundness" and "actuarial balance or imbalance" could be seriously impaired.

It should be noted that the Ways and Means Committee version of H.R. 17550 was based on estimates for a $9000 base and contained no data on actuarial costs based on escalating benefits and wage base. We suggest the proposed automatic escalators will jeopardize the financial soundness of the system. We suggest further that this matter requires inquiry in depth.

The enormity of the problems caused by the automatic escalators in the remote future can be gauged by a rough illustration. Under H.R. 17550, in 1971 the 5.2% tax rate and the $9000 taxable wage base will generate a maximum annual employee tax of $468 tax revenues are expected to be $47.7 billion; and benefits are expected to be $44.3 billion. Excess tax collections would amount to $3.4 billion.[9] In 1993, the 6.5% tax rate and a possible $22,000 taxable wage base could generate a maximum annual employee tax of $1,430—3.05 times the maximum tax in 1971. All other things being equal, the 1993 tax revenue could be $145.5 billion. Also in 1993, the operation of the 3% per year automatic benefit escalator, exclusive of the growth in number of beneficiaries, could increase annual benefits by 96% to $86.8 billion. Excess tax collections in 1993 could be $58.7 billion. It is not claimed that the foregoing is a probable result; but on the other hand, who can claim that it is not a possible result?

The shift of the future social security tax costs to middle and higher income groups

The bulk of future social security tax costs will be shifted to the middle and higher income groups if the automatic taxable wage escalator is adopted. Its adoption can easily foreclose the possibility of equitable upward tax rate revision in the future. The argument will be made that H.R. 17550 does in fact increase the social security tax rates for everybody—and so it does. But see Tables IV and V for the extreme variations in the results of the escalation in taxable wages at various earnings levels.

Table IV displays the tax rates, taxable wage base, and the maximum annual employee social security tax under the present law—as they would be under H.R. 17550 with a fixed $9,000 wage base and also with the proposed escalating wage base. Particular attention is directed to the annual *increase* in the maximum tax under the proposed escalating wage base: $62 in 1971; $207 in 1975; $406 in 1980; $640 in 1985; $788 in 1990; $970 in 1993. Has anyone asked an employee how he feels about this?

Table V displays the prospective annual increase in the annual employee social security tax for those earning less than the present maximum taxable wage of $7,800—specifically, at $3,000, $5,000, and $7,000 annual earnings. Under H.R. 17550 the greater increase in the annual tax for these wage levels will occur in and after 1987. It will be: $18 at the $3,000 earnings level; $30 at the $5,000 earnings level; $42 at the $7,000 earnings level.

A visual result of the data in Tables IV and V is displayed in graph form in Chart III. The graph emphasizes in dramatic fashion that the planners and supporters of automatic escalation may have been carried away by the idea that automatic wage escalators could solve the financing aspect of social security without considering the impact of the proposal on the taxpayers and their pocketbooks! There are those who would not be disturbed about, or who would eagerly

[9] Table III, page 80; Table IV, page 81; and Table E, page 92, House Report 91-1096.

support, the automatic wage escalator on the ground that it is an effective substitute to progressive tax rates as is found in income taxation. They will contend that the principle is equitable and is in keeping with "ability to pay." We contend here that those who will pay the tax should have some say in the matter. The unfortunate aspect, however, is that the commitment will fasten on today's children and unborn generations!

The Prospective Cumulative Effect of H.R. 17550 Taxation is Staggering

Table VI displays the accumulated maximum annual employee social security tax that will be paid, from 1937 or the year in which age 21 is attained if later, through age 64. The accumulated tax, for OASDI and HI purposes, has been calculated for persons aged 1 to 64 (in five-year intervals) under the present law and also as proposed under H.R. 17550. In the latter instance, the calculations have been made with a fixed $9000 taxable wage base, and with the proposed escalating wage base progressing to $22,000 in 1993.

The postponed and little-recognized impact of the cumulative taxes on today's young people is made apparent in Table VI. Under the present law, persons aged 64 in 1970 will have paid $3,766 social security tax for their benefit coverage but those under age 16 in 1970 will have to pay more than $20,000 tax for their benefit coverage. Even if under H.R. 17550 the taxable wage base remained constant at $9000, those under age 16 in 1970 would have to pay almost $26,000 tax for their benefit coverage—specifically 27% more.

Table VI indicates the extent of the staggering increase in tax costs which will occur if the automatic escalation in the taxable wage base is enacted. The increase will rise as the age in 1970 decreases. Although a person age 64 in 1970 still will have paid only $3766 in tax, a baby one year old in 1970 can expect to pay $62,530 in tax if he earns the maximum earnings during his assumed career!

A summary of the increase in accumulated tax under an automatic escalating wage base proposed in H.R. 17550 as compared to the present law is as follows:

ACCUMULATED MAXIMUM EMPLOYEE SOCIAL SECURITY TAX

Age in 1970	Current law	H.R. 17550 (escalating base)	Increase	
			Dollars	Percent
60	$5,488	$5,792	$304	5.5
50	9,819	13,928	4,109	41.8
40	14,091	26,145	12,054	85.5
30	17,838	39,590	21,752	121.9
20	19,964	51,415	31,451	157.5
10	20,202	59,332	39,130	193.7
1	20,241	62,530	42,289	208.9

This needs no further explanation save for the reminder that the above tax costs are matched by equal employer social security tax costs. It would seem that those who believe that the employer social security tax is not passed along to the consumer and is not borne by the employer, but rather is borne by the employee, cannot in logic support the enactment of the automatic escalating wage base. The proposal should give some concern, too, to those who believe that the entire cost of Social Security is passed along to the consuming public.

It is submitted that automatic escalating wage base could drive private industrial contributory retirement plans out of existence.

The diminishing return on the investment in social security

Table VII attached displays the monthly maximum male primary insurance amount (PIA) under the present law and under H.R. 17550 if the proposed $9000 taxable wage base were to remain constant and if the automatic escalator in taxable wages and benefits were to be enacted.

The data show that the proposed benefit formula based on a fixed $9000 taxable wage base will produce a maximum PIA of $283 per month in the year 2010—but only for those under age 26 in 1970. Although H.R. 17550 provides a 5% increase for current beneficiaries, the proposed benefit formula with a fixed $9000 taxable wage base, in contrast to the present benefit schedule, will provide a 12%-1.% increase in benefits for future beneficiaries. This is not an unreasonable prospect.

The data also show that under the assumed increase in the automatic escalating taxable wage base, the maximum monthly PIA could be $234 in 1975; $266 in 1980; and $283 in 1985; exclusive of the operation of the 3% automatic escalator in benefits.

The data further show what could happen to the maximum monthly PIA under the escalating taxable wage base and

(1) if the proposed benefit table in Section 215(a) of the Social Security Act were to be increased 3% per year after 1971; or

(2) if the maximum monthly PIA were to be raised periodically after 1985 to retain the 38% maximum PIA—average monthly wage ratio as the maximum taxable wage base would be increased through the operation of the proposed automatic escalator.[19]

The column on Table VII depicting the future trend in the maximum monthly PIA under an assumed 3% increase in benefits per year (which could be an extreme assumption) shows that it could be $704 instead of $283 by the year 2010, and $1,005 by the year 2034. (In the remote year of 2034, a one-year old baby in 1970 would retire at age 65; and after having earned the maximum yearly earnings of $22,000 from 1993 on, would receive $1,005 per month as his PIA. This would be a 54.5% replacement of prior monthly earnings ($1833).

The column on Table VII depicting the future trend in the maximum monthly PIA shows a more moderate result if the Congress were to revise periodically the formula underlying the benefit schedule in Section 215(a) of the Social Security Act. The maximum monthly PIA, if adjusted periodically to maintain the present 38% replacement of prior earnings, would progress to $697 by the year 2034. This, and any other result, could be achieved by continual Congressional action without the necessity of having an automatic and inflexible escalator in benefits.

It will be argued that the automatic escalator in benefits is appropriate because of the very reason that it could produce a greater replacement of prior earnings—a desirable goal. It will also be argued that the benefit escalator would force benefits to keep pace with anticipated rising price levels and rising wages. The goal is indisputable—the proposed mechanism is not. It contended that such a proposed commitment on benefits mandated by the current Congress and to the fulfilled by taxes on future generations is grossly in appropriate. The first time a future Congress is forced to consider applying limits on or cutting back prospective benefit levels—and this is not inconceivable—public confidence in the social security system will be shattered.

Table VIII displays an attempt to relate the social security tax cost to lifetime PIA benefits. For this purpose, the accumulated employee OASDI tax, exclusive of the HI tax, has been doubled to include the employer tax cost, and then 77% of the doubled amount has been considered to be allocable to the purchase of a lifetime PIA annuity. The lifetime benefits have been computed on the basis of life expectancy of 15 years at age 65. (Unquestionably, life expectancy will improve in the remainder of this century and in the next century; so to an indeterminable extent, the lifetime benefits in the distance future will be understated.) To develop extreme results, the future progress of the PIA under the assumed 3% yearly benefit increase, as shown on Table VII, has been used.

There are certain conclusions that can be drawn from the data on Table VIII, howsoever imperfect the assumptions and projections used:

(1) The lifetime cost of maximum social security to the individual and his employer could double by the year 2000 and triple by the year 2030 if the automatic wage base escalator is enacted.

(2) The increase in lifetime dollar tax costs, apart from potential benefits, is alarming even if considered in light of rising wage and cost-of-living levels.

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[19] See the following table:

	Maximum PIA	Maximum average monthly earnings
Present law	$250.70	$650 (equals 38.5 percent).
Proposed	283.00	$750 (equals 37.7 percent).

(3) Even under the present law, the present younger workers are disadvantaged in relation to the older workers (age 50–64):

(a) A person age 64 in 1970 could get $35,000 in benefits for $5,500.

(b) A person age 25 in 1970 could get $45,000 in benefits for $25,600.

(c) A person age one in 1970 could get $45,000 in benefits for $26,400.

(d) Today's one-year old will have paid 4.8 times more tax costs of today's 64-year old while his benefits will be only 1.3 times greater.

(4) Automatic escalation in wages and benefits under H.R. 17550 will still favor the present older workers.

(a) Under automatic wage escalation, the lifetime dollar tax costs of today's one-year old person could be almost 15 times greater than that of today's 64-year old person.

(b) Under automatic benefit escalation, the lifetime benefit, exclusive of improved life expectancy, of today's one-year old person could be only 4.6 times greater than that of today's 64-year old person ($180,900÷$38,800).

The foregoing has been concerned solely with maximum tax costs and maximum benefits. It does not apply to workers who earn less than the maximum earnings. For these workers, the tax costs are smaller and the benefits are greater because of the operation of the benefit formula, and because the ultimate maximum PIA, when raised by Congress, is not obtainable until many years after the change.

The PIA benefit formula relates the benefit to a percentage of various segments of the career average monthly earnings (AME) determined at retirement. Historically, the benefit formula has produced a greater wage replacement for low income workers than it has for the higher income workers. For the latter, it becomes less of a bargain with each passing decade.

Increased employer social security tax costs—Effect on profits and prices

It is fair to state that the business community is stunned by the magnitude of the social security tax increases that could occur under the automatic escalating wage base proposal. In theory, the initial proposal seemed innocuous but when estimated projections of the future tax costs became public knowledge—and this occurred only after the House Ways and Means Committee reported H.R. 17550 with a fixed $9000 taxable wage base—the reaction was one of sheer disbelief.

Coming as it does during a period of a mild recession, where there exists prior restraints, contract credit, and a serious cost-price squeeze, there is reason for dismay over the fact that the House of Representatives voted for automatic escalators despite their absence in H.R. 17550 when that bill was reported from the House Ways and Means Committee.

We can only conclude that it appears to be the intention of a large segment of Congress (1) to fasten a greater tax burden on high wage industries, thus penalizing attempts to compensate employees fairly; (2) to disregard the inflationary effect of mandated escalation of social security taxes and benefits; and (3) to disregard the probability that this tax cost will result in reduced earnings for many employers. Reduced earnings are not an inducement for business expansion and the creation of jobs.

Some somber statistics supporting our concern about the growth of social security tax costs were contained in a recent survey on employee benefit plan costs conducted by the Chamber of Commerce of the United States. These statistics show:

	1959	1969	Percentage increase
Average weekly wages	$95.48	$141.44	+48
Employer-paid fringe benefits	21.77	39.46	+81
Including:			
Social security tax	2.15	6.44	+200
Private pensions	3.83	5.88	+61

In the last ten years the employer's social security tax cost, on the average:

(1) has become the largest and most expensive single element of an employer's total benefit plan costs;

(2) has shown the greatest percentage increase of all fringe benefits;

(3) has increased 4 times faster than wages;

(4) has surpassed the employer private pension plan costs.

An effective alternate to automatic escalation in social security

The most effective argument advanced by the proponents of automatic escalators is that the Congress has lagged in the past in raising benefits. This may have been true during the period 1959–1964, but it most certainly has not been true since 1965. Benefits have been increased 35% in three separate actions since 1965.

An effective alternative to automatic escalators would be a formal resolution or declaration of policy by the Congress to reexamine the social security benefit and tax structure regularly as the cost of living increases. In actuality, this has been the practice of Congress since 1965. Additionally, for the past three decades Congress has been concerned both with the matter of increasing benefits and with the matters of expanding coverage, liberalizing eligibility and reducing disqualification provisions and providing new classes of beneficiaries. Conceivably the system can be strained if this continues. It seems appropriate that priority be given to the matter of increasing benefits periodically and to the extent deemed necessary and that less attention be given to these other matters.

We contend that no one has the prescience or clairvoyance to be able to look ahead 50 and 60 years into the future and be able to say with certainty that there will be rising wages, prices and cost-of-living. No one can say that the automatic escalators will result in a financially sound social security system, supported by favorable public opinion, equitable to all classes of beneficiaries, and adequate in relation to the then existing economy. We contend it is foolhardy to accept the presumptious premise—the untried theory—that a simple but yet automatic and flexible formula can operate satisfactorily in a society as complex as ours is and will be. The premise of automatic escalators ignores the external and internal pressures on our economic and political institutions.

In light of the present daily challenges to our institutions, we ask the Congress to ponder three questions:

What would be the result if, as an increasingly alarming number of our citizens believe, individual proprietorships and corporations should be taxed out of existence or nationalized? Where would the employer share of social security revenue come from? What would be the result if an increasingly alarming number of our youngsters "drop-out" of our economic society or refrain from seeking high-paying jobs and wages and thus avoid paying the higher social security taxes necessary to pay the social security benefits to the low income groups?

THE PROBLEM OF UNIVERSAL HEALTH CARE COVERAGE

We urge this Committee in determining the future course of Social Security taxation and benefits, also to bear in mind the unavoidable thrust and impact of some form of universal health insurance program. It is our judgment that each passing year will bring us nearer to the adoption of some program which in all probability will utilize the payroll tax mechanism in whole or in part. Already most of the proposals would employ this mechanism.

Preliminary estimates indicate that universal health care coverage can cost as much as $50 billion annually, depending upon the scope of the proposals. This can be a staggering *additional* load to place on the payroll tax whether or not it is passed on to the consumer in the form of higher prices.

The following State Chambers of Commerce have endorsed this statement:

Alabama State Chamber of Commerce
Colorado Association of Commerce & Industry
Connecticut State Chamber of Commerce, Inc.
Delaware State Chamber of Commerce, Inc.
Georgia Chamber of Commerce
Idaho State Chamber of Commerce
Indiana State Chamber of Commerce
Kansas State Chamber of Commerce
Kentucky Chamber of Commerce
Maine State Chamber of Commerce
Michigan State Chamber of Commerce
Minnesota Association of Commerce & Industry
Montana Chamber of Commerce
New Jersey State Chamber of Commerce
Empire State Chamber of Commerce
Ohio Chamber of Commerce
Pennsylvania Chamber of Commerce
South Carolina State Chamber of Commerce
Greater South Dakota Association
East Texas Chamber of Commerce
South Texas Chamber of Commerce
West Texas Chamber of Commerce
Lower Rio Grande Valley Chamber of Commerce
Virginia State Chamber of Commerce
West Virginia Chamber of Commerce
Wisconsin State Chamber of Commerce

CHART I

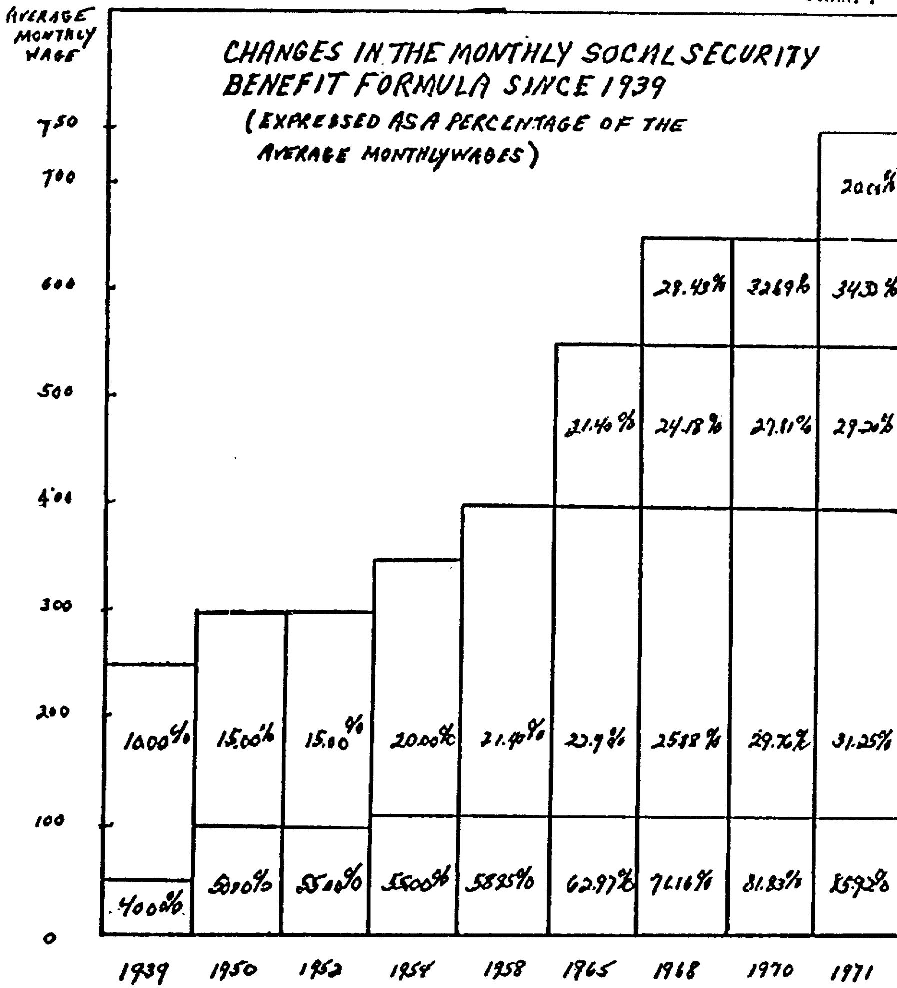

CHART II

HEW ESTIMATES (1)

MAXIMUM TAXABLE EARNINGS UNDER "AUTOMATIC ESCALATOR" PROPOSAL IN HR 17550

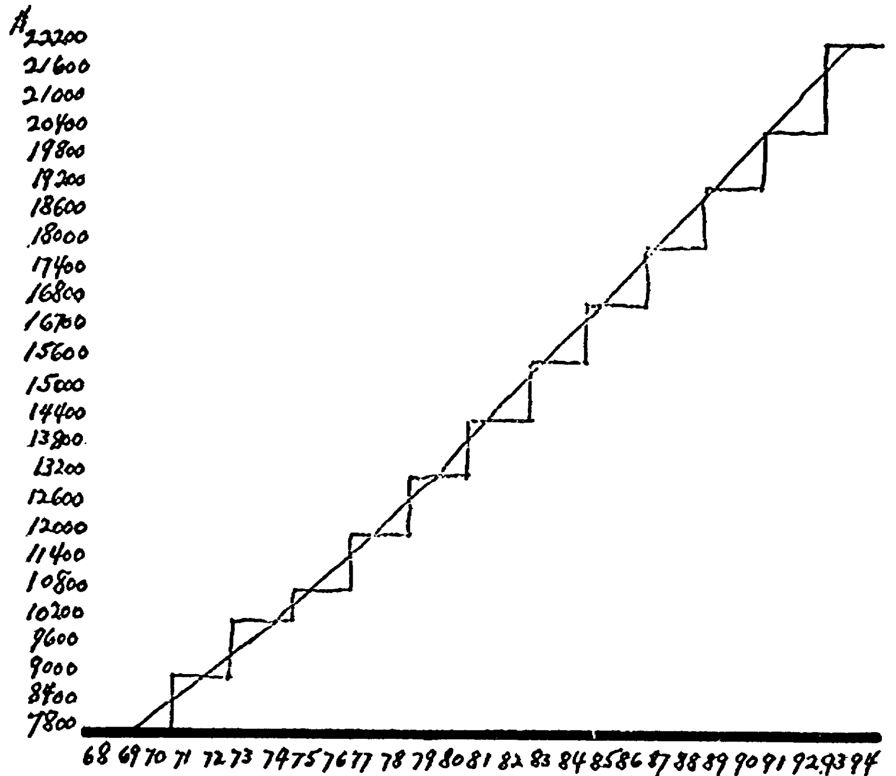

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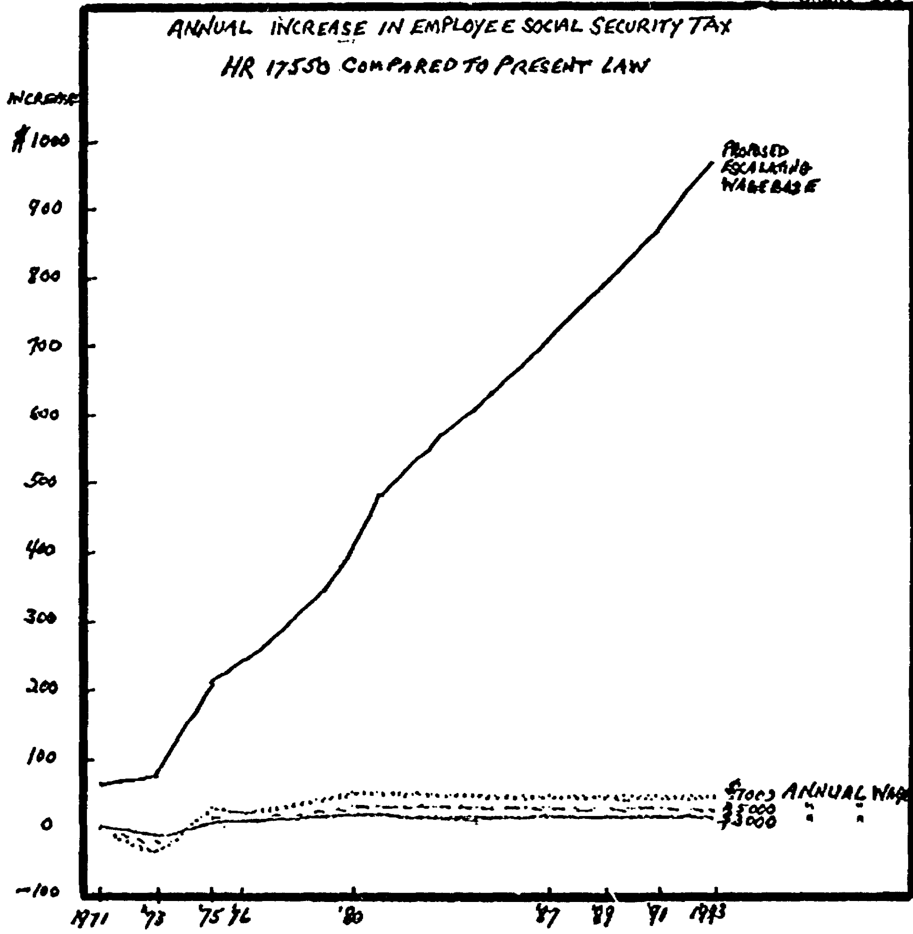
CHART III



Appendix A

I. Criteria used in examples:

(1) All examples are based on benefits receivable under the New York Workmen's Compensation Law. Benefits are based on 66⅔ of a workers' average weekly wage with $85 maximum.

(2) The best 5 year average wages of an employee for purposes of establishing his disability rate is an estimated figure as these are not actual cases.

(3) The disability rate is estimated using the Social Security Handbook as a guide.

(4) All figures are rounded off to the nearest dollar, and *are approximate* benefits due.

II. In the examples, (case numbers 1 thru 6) the five year average wage figure used (Roman Numeral II in each example) is an example based on an analysis of the actual wage increases that have occurred between 1965 and 1969 as shown in the "*Table of Wages*" Appendix A, Page 2.

TABLE OF WAGES

(Gross Earnings of Nonsupervisory Workers by Industry)

	December of year—					5-year average
	1969	1968	1967	1966	1965	
Plumbing, heating, air conditioning:						
Gross average weekly earnings	$210.84	$192.06	$175.83	$165.36	$156.78	
Annual	10,964	9,987	9,143	8,599	8,153	9,369
Masonry, stoneworker, plastering:						
Weekly	176.47	148.80	142.23	140.22	135.76	
Annual	9,176	7,738	7,427	7,291	7,060	7,738
Finance, insurance, real estate:						
Weekly	109.89	104.99	99.16	93.62	90.88	
Annual	5,714	5,459	5,156	4,868	4,726	5,185
Retail trade:						
Weekly	79.79	76.47	72.22	69.65	67.71	
Annual	4,149	3,976	3,755	3,622	3,521	3,805

Source: "Employment and Earnings," U.S. Department of Labor, table C-2.

Case No. 1

Employee statistics—Single:

I. Employee's average wages for workmen's compensation computation:	
Year	$5,200
Month	433
Week	100
II. Employee's best 5-year average on which social security benefits are based:	
Year	4,800
Month	400
III. Workmen's compensation rate (month)	290
Social security rate (month)	177
IV. Gross amount earned by employee prior to accident	433
Less approximate deductions:	
1. Federal income tax 12.5 percent	59
2. FICA 5 percent	22
Total deductions	81
Employee take home pay	352
V. Employee limited to 80 percent of II or	320
Payments as follows workmen's compensation 290 social security	30
Under 100-percent limit—employee would receive	400
Payments as follows workmen's compensation 290 social security	110
VI. Amount of additional dollars employee would receive per month while at home rather than at work under 100-percent limit (V minus IV)	48

Case No. 2

Employee statistics—Married with 1 child:

I. Employee's average wages for workmen's compensation computation:	
Year	$5,200
Month	433
Week	100
II. Employee's best 5-year average on which social security benefits are based:	
Year	4,800
Month	400
III. Workmen's compensation rate (month)	290
Social security rate (month)	354
IV. Gross amount earned by employee prior to accident	433
Less approximate deductions:	
1. Federal income tax 8 percent	35
2. FICA 5 percent	22
Total	57
Employee take home pay	376
V. Employee limited to 80 percent of II or	320
Payments as follows workmen's compensation 290 social security	30
Under 100-percent limit—employee would receive	400
Payments as follows workmen's compensation 290 social security	110
VI. Amount of additional dollars employee would receive per month while at home rather than at work under 100-percent limit	24

Case No. 3

Employee Statistics—Single:

I. Employee's average wages for workmen's compensation computation:	
Year	$6,660.00
Month	550.00
Week	127.00
II. Employee's best 5-year average on which social security benefits are based:	
Year	6,000.00
Month	500.00
III. Workmen's compensation rate (month)	368.00
Social security rate (month)	205.00
IV. Gross amount earned by employee prior to accident	550.00
Less approximate deductions:	
1. Federal income tax 15 percent	82.50
2. FICA 5 percent	27.50
Total deduction	110.00
Employee take home pay	440.00
V. Employee limited to 80 percent of II or	400.00
Payments as follows workmen's compensation 368 social security	32.00
Under 100 percent limit—employee would receive	500.00
Payments as follows workmen's compensation 368 social security	132.00
VI. Amount of additional dollars employee would receive per month while at home rather than at work under 100 percent limit	60.00

Case No. 4

Employee statistics—Married with 1 child:

I. Employee's average wages for workmen's compensation computation:	
Year	$6,660.00
Month	550.00
Week	127.00
II. Employee's best 5-year average on which social security benefits are based:	
Year	6,000.00
Month	500.00
III. Workmen's compensation rate (month)	368.00
Social security rate (month)	408.00
IV. Gross amount earned by employee prior to accident	550.00
Less approximate deductions:	
1. Federal income tax 9½ percent	52.25
2. FICA 5 percent	27.50
Total deductions	79.75
Employee take home pay	470.00
V. Employee limited to 80 percent of II or	400.00
Payments as follows workmen's compensation 368 social security	32.00
Under 100 percent—employee would receive	500.00
Payments as follows workmen's compensation 368 social security	132.00
VI. Amount of additional dollars employee would receive per month while at home rather than at work under 100 percent limit	30.00

Case No. 5

Employee statistics—Single:

I. Employee's average wages for workmen's compensation computation:	
Year	$10,800
Month	900
Week	207
II. Employee's best 5-year average on which social security benefits are based:	
Year	9,600
Month	800
III. Workmen's compensation rate (month)	290
Social security rate (month)	250
IV. Gross amount earned by employee prior to accident	900
Less approximate deductions:	
1. Federal income tax 20 percent	180
2. FICA 5 percent	45
Total deductions	225
Employee take home pay	675
V. Employee limited to 80 percent of II or 640 but would receive	540
Payments as follows workmen's compensation 290 social security	250
Under 100 percent limit, employee would receive	540
Payments as follows workmen's compensation 290 social security	250
VI. Amount of additional dollars employee would receive per month while at home rather than at work under 100 percent limits increase would have no effect	--------

Case No. 6

Employee statistics—Married with 1 child:

I. Employee's average wages for workmen's compensation computation:	
Year	$10,800
Month	900
Week	207
II. Employee's best 5-year average on which social security benefits are based:	
Year	9,600
Month	800
III. Workmen's compensation rate (month)	290
Social security rate (month)	500
IV. Gross amount earned by employee prior to accident	900
Less approximate deductions:	
1. Federal income tax 13 percent	117
2. FICA 5 percent	45
Total deductions	162
Employee take home pay	778
V. Employee limited to 80 percent of II or	640
Payments as follows workmen's compensation 290 social security	350
Under 100 percent limit, employee would receive	790
Payments as follows workmen's compensation 290 social security	500
VI. Amount of additional dollars employee would receive per month while at home rather than at work under 100 percent limit	22

Table I.—*Social Security Monthly P.I.A. Benefit Formula*

1939 Act—Effective 1/1/40; 40% of 1st $50 of average monthly wage (AMW) +10% of the next $200 of AMW+1% for each year beginning in 1937; Min. —0; Max.—$60.

1950 Act—Effective 9/1/50; 50% of 1st $100 of AMW+15% of next $200 of AMW;[1] Min.—$20; Max.—$80.

1952 Act—Effective 9/1/52; 55% of 1st $100 of AMW+15% of next $200 of AMW; Min.—$25; Max.—$85.

1954 Act—Effective 9/1/54; 55% of 1st $110 of AMW+20% of next $240 of AMW; Min.—$30; Max.—$103.50, 1/1/56; $108.50, 7/1/56; Lowest 4 years omitted.

1956 Act—Lowest 5 years omitted.

1958 Act—Effective 1/1/59; 58.85% of 1st $110 of AMW+21.4% of next $290 of AMW; Min.—$33; Max.—$127.

1961 Act—Effective 8/1/61; Min.—$40.

1965 Act—Effective 1/1/65; 62.97% of 1st $110 of AMW+22.9% of next $290 of AMW+21.4% of next $150 of AMW; Min.—$44; Max.—$168.

1967 Act—Effective 2/1/68; 71.16% of 1st $110 of AMW+25.88% of next $290 of AMW+24.18% of next $150 of AMW+28.43% of next $100 of AMW; Min.—$55; Max.—$218.[2]

1969 Act—Effective 1/1/70; 81.83% of 1st $110 of AMW+29.76% of next $290 of AMW+27.81% of next $150 of AMW+32.69% of next $100; Min.—$64; Max.—$250.70.[2]

1970 proposal—Effective 1/1/71; 85.92% of 1st $110 of AMW+31.25% of next $290 of AMW+29.20% of next $150 of AMW+34.32% of next $100 of AMW +20.00% of next $100; Min.—$67.20; Max.—$283.[2]

[1] New formula based on years of coverage after 1950.
[2] This maximum is attainable only in the year 2006.

TABLE II.—SOCIAL SECURITY MONTHLY BENEFITS, AS ADJUSTED SINCE 1939

Components of average monthly wage	1939	1950	1952	1954	1958	1965	1968	1970	1971 (proposed)
0 to $50	$20.00	$25.00	$27.50	$27.50	$29.43	$31.49	$35.58	$40.92	$42.96
$50 to $100	5.00	25.00	27.50	27.50	29.42	31.48	35.58	40.91	42.96
$100 to $110	1.00	1.50	1.50	5.50	5.89	6.30	7.12	8.18	8.59
$110 to $250	14.00	21.00	21.00	28.00	29.96	32.06	36.23	41.66	43.75
$250 to $300		7.50	7.50	10.00	10.70	11.45	12.94	14.88	15.63
$300 to $350				10.00	10.70	11.45	12.94	14.88	15.62
$350 to $400					10.70	11.45	12.94	14.88	15.62
$400 to $550						32.10	36.27	41.72	43.80
$550 to $650							28.43	32.69	34.32
$650 to $750									20.00
Minimum	0	20.00	25.00	30.00	33.00	44.00	55.00	64.00	67.20
Maximum (rounded)	40.00	80.00	85.00	108.50	126.80	167.78	218.03	250.70	283.25
					127.00	168.00	218.00		283.00
First $110	26.00	51.50	60.50	60.50	64.74	69.27	78.28	90.01	94.51
Next $290	14.00	28.50	28.50	48.00	62.06	66.41	75.05	86.30	90.62
Next $150						32.10	36.27	41.71	43.80
Next $100							28.43	32.69	34.32
Next $100									20.00
Total	40.00	80.00	85.00	108.50	126.80	167.78	218.03	250.71	283.25

PIA AS A PERCENT OF AVERAGE MONTHLY WAGE

	1939	1950	1952	1954	1958	1965	1968	1970	1971 (proposed)
$110	23.4	46.4	54.5	55.0	58.3	62.4	70.5	81.1	85.1
$250	16.0	29.0	31.0	35.4	37.9	40.5	45.8	52.7	55.3
$300		26.7	28.3	32.8	35.1	37.6	42.5	48.9	51.3
$350				31.0	33.2	35.4	40.0	46.1	48.4
$400					31.7	33.9	38.3	44.1	46.3
$550						30.5	34.5	39.6	41.6
$650							33.5	38.6	40.5
$750									37.8

TABLE III.—AVERAGE QUARTERLY SOCIAL SECURITY TAXABLE WAGES FOR 1ST CALENDAR QUARTER [1]

Year	1st quarter average taxable wage	Maximum annual taxable wage	Biennial percentage increase	
			Over 1955	1957-59=100
1955	$815	$4,200		
1957	899	4,200	10.3	
1959	952	4,800	16.8	
1961	1,011	4,800	24.0	10.0
1963	1,086	4,800	33.3	18.2
1965	1,154	4,800	41.6	25.5
1967	1,291	6,600	58.4	40.5
1969	[2] 1,455	7,800	78.5	58.3

[1] Table Q-3 June 1970 Social Security Bulletin.
[2] 1969 over 1967, +12.7 percent.

Note: Average annual increase: 15 years, 5.2 percent; 10 years, 5.8 percent.

TABLE IV.—COMPARISON OF MAXIMUM ANNUAL EMPLOYEE SOCIAL SECURITY TAX

	Present law			Proposed—H.R. 17550						
				Fixed base			Escalating base			
Year	Base	OASDHI Tax rate (percent)	Tax	Base	OASDHI Tax rate (percent)	Tax	Base	OASDHI Tax rate (percent)	Tax	Increase: Escalation over present
1971	$7,800	5.2	$405.60	$9,000	5.2	$468.00	$9,000	5.2	$468.00	$62.40
1972	7,800	5.2	405.60	9,000	5.2	468.00	9,000	5.2	468.00	62.40
1973	7,800	5.65	440.70	9,000	5.2	468.00	10,200	5.2	530.40	89.70
1974	7,800	5.65	440.70	9,000	5.2	468.00	10,200	5.2	530.40	89.70
1975	7,800	5.65	440.70	9,000	6.0	540.00	10,800	6.0	648.00	207.30
1976	7,800	5.70	444.60	9,000	6.0	540.00	10,800	6.0	648.00	203.40
1977	7,800	5.70	444.60	9,000	6.0	540.00	12,000	6.0	720.00	275.40
1978	7,800	5.70	444.60	9,000	6.0	540.00	12,000	6.0	720.00	275.40
1979	7,800	5.70	444.60	9,000	6.0	540.00	13,200	6.0	792.00	347.40
1980	7,800	5.80	452.40	9,000	6.5	585.00	13,200	6.5	858.00	405.60
1981	7,800	5.80	452.40	9,000	6.5	585.00	14,400	6.5	936.00	483.60
1982	7,800	5.80	452.40	9,000	6.5	585.00	14,400	6.5	936.00	483.60
1983	7,800	5.80	452.40	9,000	6.5	585.00	15,600	6.5	1,014.00	561.60
1984	7,800	5.80	452.40	9,000	6.5	585.00	15,600	6.5	1,014.00	561.60
1985	7,800	5.80	452.40	9,000	6.5	585.00	16,800	6.5	1,092.00	639.60
1986	7,800	5.80	452.40	9,000	6.5	585.00	16,800	6.5	1,092.00	639.60
1987	7,800	5.90	460.20	9,000	6.5	585.00	18,000	6.5	1,170.00	709.80
1988	7,800	5.90	460.20	9,000	6.5	585.00	18,000	6.5	1,170.00	709.80
1989	7,800	5.90	460.20	9,000	6.5	585.00	19,200	6.5	1,248.00	787.80
1990	7,800	5.90	460.20	9,000	6.5	585.00	19,200	6.5	1,248.00	787.80
1991	7,800	5.90	460.20	9,000	6.5	585.00	20,400	6.5	1,326.00	865.80
1992	7,800	5.90	460.20	9,000	6.5	585.00	20,400	6.5	1,326.00	865.80
1993	7,800	5.90	460.20	9,000	6.5	585.00	22,000	6.5	1,430.00	969.80

TABLE V.—ANNUAL EMPLOYEE SOCIAL SECURITY TAX

	$3,000 wage			$5,000 wage			$7,000 wage		
Year	Present	H.R. 17550	Increase	Present	H.R. 17550	Increase	Present	H.R. 17550	Increase
1971	$156.00	$156		$260.00	$260		$364.00	$364	
1973	169.50	156	$-13.50	282.50	260	$-22.50	395.50	364	$-31.50
1975	169.50	180	+9.50	282.50	300	+17.50	395.50	420	+34.50
1976	171.00	180	+9.00	285.00	300	+15.00	399.00	420	+21.00
1980	174.00	195	+21.00	290.00	325	+35.00	406.00	455	+49.00
1987	177.00	195	+18.00	295.00	325	+30.00	413.00	455	+42.00

TABLE VI.—ACCUMULATED MAXIMUM EMPLOYEE SOCIAL SECURITY TAX FROM 1937, OR AGE 21 IF LATER, THROUGH AGE 64

			H.R. 17550 proposed tax rates	
Age in 1970	Will retire in—	Current law	Fixed $9,000 wage base	Escalating wage base [1]
64	1971	$3,766	$3,766	$3,766
60	1975	5,488	5,638	5,762
55	1980	7,677	8,338	9,230
50	1985	9,819	11,143	13,928
45	1990	11,955	13,918	19,550
40	1995	14,091	16,678	26,145
35	2000	16,074	19,285	32,977
30	2005	17,838	21,673	39,590
25	2010	19,323	23,782	45,924
20	2015	19,964	25,047	51,415
15	2020	20,132	25,560	55,920
10	2025	20,202	25,740	59,332
5	2030	20,241	25,740	61,490
1	2034	20,249	25,740	62,530

[1] Per table III.

TABLE VII.—MONTHLY MAXIMUM MALE PRIMARY INSURANCE AMOUNT (PIA)

Will retire in	Age in 1970	Current law	Fixed $9,000 wage base	H.R. 17550 escalating wage base		Maximum PIA maintained at 38 percent of average monthly earnings
				No escalation in benefits	3 percent yearly benefit increase after 1971 [1]	
1971	64	$194	$210	$210	$210	
1975	60	204	229	234	[2] 262	
1980	55	214	246	266	[3] 338	
1985	50	218	255	283	[4] 402	$293
1990	45	223	262		[5] 462	336
1995	40	227	266		[5] 523	381
2000	35	238	276		[5] 582	457
2005	30	248	282		[5] 643	527
2010	25	251	283		[5] 704	585
2015	20				[5] 764	632
2020	15				[5] 824	667
2025	10				[5] 884	688
2030	5				[5] 945	[6] 697
2034	1				[5] 1,005	[6] 697

[1] Without further change in benefit scheduled in sec. 215(a), Social Security Act.
[2] 112 percent.
[3] 127 percent.
[4] 142 percent.
[5] PIA of $402 in 1985 increased 3 percent per year.
[6] Maximum average monthly earnings ($1,833) reached in 2029—based on maximum yearly taxable earnings of $22,000 on and after 1993.

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TABLE VIII.—TOTAL OASDI TAX COST

Age in 1970	Will retire in—	Accumulated maximum employee OASDI tax (excluding HI tax)[1]		154 percent of accumulation (representing 77 percent of combined employee-employer OASDI tax)		Lifetime benefit (PIA×180), H.R. 17550			Lifetime benefit-cost ratio, H.R. 17550	
		Present	H.R. 17550	Present	H.R. 17550[1]	Present	No escalation	Escalating benefits[2]	Present	Escalating
64	1971	$3,569	$3,569	$5,496	$5,496	$34,920	$38,000		6.4 to 1	7.1 to 1.
0	1975	5,067	5,182	7,803	7,980	36,720	42,120	$47,160	4.7 to 1	5.9 to 1.
55	1980	7,017	8,132	10,806	12,523	38,520	47,880	60,840	3.5 to 1	4.9 to 1.
50	1985	8,847	12,028	13,624	18,523	39,240	50,940	72,360	2.9 to 1	3.9 to 1.
45	1990	10,647	16,762	16,396	25,813	40,140	50,940	83,160	2.4 to 1	3.2 t9 1.
40	1995	12,432	22,317	19,145	34,368	40,860	50,940	94,140	2.1 to 1	2.7 to 1.
35	2000	14,064	28,049	21,658	43,195	42,840	50,940	104,760	2.0 to 1	2.4 to 1.
30	2005	15,477	33,283	23,834	51,256	44,640	50,940	115,744	1.9 to 1	2.3 to 1.
52	2010	16,611	38,796	25,580	59,746	45,180	50,940	126,720	1.8 to 1	2.1 to 1.
02	2015	17,098	43,383	26,331	66,810	45,180	50,940	137,520	1.7 to 1	2.1 to 1.
51	2020	17,160	47,280	26,426	72,811	45,180	50,940	148,320	1.7 to 1	2.0 to 1.
01	2025	17,160	50,204	26,426	77,314	45,180	50,940	159,120	1.7 to 1	2.1 to 1.
5	2030	17,160	52,030	26,426	80,542	45,180	50,940	170,100	1.7 to 1	2.1 to 1.
1	2034	17,160	52,910	26,426	81,481	45,180	50,940	180,900	1.7 to 1	2.2 to 1.

[1] On escalating wage basis only.
[2] Benefits escalating 3 percent per year after 1985 (per VI).

Senator WILLIAMS. Thank you very much.

The committee will stand in recess temporarily. There is a vote in the Senate, and the chairman will be back in just a minute.

Mr. HENKEL. Thank you.

Am I excused, sir?

Senator WILLIAMS. Yes. That completes your statement; does it?

Mr. HENKEL. Yes.

Senator WILLIAMS. All right. Your full statement has been placed in the record and you will be excused.

Mr. HENKEL. Thank you.

(Short recess.)

The CHAIRMAN. The next witness will be Mr. Mondani, director of research, Connecticut Education Association, on behalf of the National Education Association.

Is Mr. Mondani here?

STATEMENT OF THOMAS P. MONDANI, NATIONAL EDUCATION ASSOCIATION; ACCOMPANIED BY W. JACK TENNANT, COORDINATOR, OFFICE OF TEACHER RETIREMENT; AND DAVID H. FOERSTER, OFFICE OF GOVERNMENT RELATIONS AND CITIZENSHIP

Mr. MONDANI. Mr. Chairman, I am Thomas P. Mondani, director of research for the Connecticut Education Association, an affiliate of the 1.1 million member National Education Association.

With me today are Mr. W. Jack Tennant, coordinator of the Office of Teacher Retirement; and Mr. David H. Foerster, senior professional associate in the NEA's Office of Government Relations and Citizenship.

We are here today to speak for the NEA in behalf of H.R. 17550, the Social Security Amendments of 1970 which, if enacted, will have a significant impact on the educational system in the States.

We are testifying on the basis of a resolution passed by National Education Association which reads in part, and I quote:

> The association will seek Federal laws to effect cost-of-living increases in the National Retirement Benefit, and urges its affiliates to seek such benefits from State legislatures and State Teacher Retirement Systems; and the association supports the principle of eligibility of teachers for part A of medicare and seeks legislation to effect it.

We strongly support H.R. 17550 and the increases in cash benefits, broadening coverage under medicare programs, and improvements in medicare, medicaid, and maternal and child health care programs.

Mr. Chairman, hundreds of thousands of teachers and other school employees now face retirement without benefit of medicare coverage. We estimate this comes to close to 700,000 instructional staff in 14 States and Puerto Rico, and it is to this that we would like to call your attention.

Our estimates do include certain people and exclude married women whom we assume would be married to other than a teacher, so we have tried to correct these down, but we do find a significant number of people who are not covered because of a decision, perhaps made years ago, not to participate in social security.

We are not asking really for a Federal fringe benefit. The act passed in the House contains a provision where the individual may pay $27 a month or whatever the Secretary determines to be the actual cost of the system.

Utilizing this option, the teacher, when he retires upon reaching age 65, can gain the benefits of the medicare plan A. We realize they also must pay for plan B, and many of our teachers do this.

In many instances, Mr. Chairman, hospitalization, which all aged people will experience, might quickly remove them from being a free individual and put them possibly on the welfare rolls.

We all know hospital costs are rising, and those teachers who retire without the benefits of medicare are unable to purchase an insurance program which would provide nearly the same benefits as medicare.

I have personal knowledge of a woman who retired, who was a teacher in the State of Connecticut, and who, fortunately, reached age 65 before the cutoff period, and she has been in and out of the hospitals over the past 3-year period, and had it not been for medicare, the poor woman probably just would not have survived.

A large number of our teachers retiring each year now face no coverage because of their age.

We would like to point out part of the statement made by Chairman Mills which states:

> But some older people who reach age 65 after 1967 cannot qualify under the transitional provision, and the provision itself will phase out as of 1974, as persons attaining age 65 in those years must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

It is these people that we seek to gain coverage for, Mr. Chairman.

Our prepared statement has evidence and charts showing the number of people and types of coverage in which they come.

We would like to thank the committee for the opportunity to present our views and to urge you to pass, through your committee, H.R. 17550 and, particularly, that section which permits these people to purchase the social security medicare portion.

(The prepared statement of Mr. Mondani follows. Hearing continues on page 883.)

Statement of Thomas P. Mondani, Director of Research, Connecticut Education Association, on Behalf of the National Education Association

Mr. Chairman and Members of the Committee: I am Thomas P. Mondani, director of research for the Connecticut Education Association, an affiliate of the 1.1 million member National Education Association. With me today is David H. Foerster, senior professional associate in the NEA's office of Government Relations and Citizenship. We are here today to speak for NEA in behalf of H.R. 17550, the Social Security Amendments of 1970, which, if enacted, will have a significant impact on the educational system in the states.

The NEA strongly supports H.R. 17550, which provides urgently needed increases in cash benefits, broadens coverage under the Medicare program, and improves the operating effectiveness of the Medicare, Medicaid, and Maternal and Child Health program. Each of these improvements touches education as it affects society generally, but the present bill offers important assistance to retiring educators who participate in Social Security and Medicare and new hope to those who do not. Our specific comments on this legislation are directed to the proposed broadening of coverage for Part A of Medicare.

Mr. Chairman, hundreds of thousands of teachers and other school employees now face retirement without benefit of Medicare coverage. *Attachment #1*, at the end of this statement, shows the pattern of Social Security coverage in state retirement systems to which teachers belong. Other public employees are covered

in some of these systems. On the basis of available facts, we estimate that approximately 700,000 instructional staff in its states and Puerto Rico are not covered. In an additional 14 states, an undermined number of teachers and other public school employees are not covered, due to divisional or local option arrangements. For example, the Texas State Teachers Association estimates that under the state's local option system, approximately 75,000 teachers are not covered by Social Security in their school employment.

The number of persons listed in this statement is not, of course, the number of persons actually involved. Those teachers who are married women and whose husbands are covered by Social Security would not be covered by the provisions of HR 17550. On the average in the U.S. as a whole, 68% of the women teachers are married. These persons, unless they are married to other teachers or public employees not covered by Social Security, would be eligible for Medicare as spouses. The largest number of potential annuitants will be those individuals who are not covered personally or indirectly by Social Security, through no fault of their own. They have devoted their lives to the education of the children of this country—and now in their retirement years face the high costs of hospitalization without the opportunity available to other retirees whose lives have been spent in more profitable careers.

Mr. Chairman, I wish to make it perfectly clear that we are not here today seeking a federal 'fringe benefit' for teachers. Virtually all teachers are contributing to a retirement system, whether Social Security is included or not. The plight of retired teachers not covered by Medicare is illustrated by *Attachment #3*, which compares the average retirement benefits for teachers in 14 states and Puerto Rico in 1969 with the cost of a 30-day hospital stay in their states in 1969. In view of the traditionally low salaries in the teaching profession, it is unlikely that many retirants are prepared to meet hospital expenses without Medicare or equivalent hospital insurance protection. It was this kind of situation that prompted the House Ways and Means Committee to preface its Report on the Social Security Amendments of 1965 with the following observations:

"Today, few older people are free of the fear that costly illness will exhaust their savings. In many instances the one or more episodes of hospitalization which virtually all aged people will experience can quickly dissipate whatever savings they have been able to accumulate for their later years. The frequent medical attention required by older people suffering from chronic illness can also be a serious drain on their financial resources.

"A large and growing proportion of the elderly applying for public assistance have had to do so only because they cannot afford needed health care. Frequently the assistance for which they must apply is very limited in scope and inadequate to meet their needs. . . .

"Since your committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, your committee recommends more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans . . ."

The two-part Medicare program—hospital insurance and supplementary medical insurance benefits—is now available to most Americans. But because of the administrative linkage to the Social Security system, it is not now possible to make the hospital insurance protection available to *all Americans*. Therefore we welcome the provision, in Sec. 202 of HR 17550, establishing eligibility for Part A benefits for those currently excluded. As explained by Chairman Mills of the House Ways and Means Committee during floor debate on HR 17550;[1]

MEDICARE FOR THE UNINSURED[2]

Another group to which we gave special attention is that group of individuals reaching age 65 who are not eligible for part A benefits. Under the bill, people reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical part of medicare. Enrollment for supplementary medical insurance is also required. Those who enroll would pay the full cost of the protec-

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[1] 89th Congress, First Session: *House Report No. 213*, p. 20.
[2] *Congressional Record*, Vol. 116, No. 82. May 21, 1970, p. H4650.

tion—$27 a month at the beginning of the program, rising as hospital costs rise. States and other organizations, through agreements with the Secretary, would be permitted to purchase such protection on a group basis for their retired—or active—employees age 65 or over, including groups of teachers who have never been covered under the program.

Present law provides hospital insurance protection under a "special transitional provision" for people—with the exclusion of certain groups—who are not qualified for cash benefits under the social security or railroad retirement program and who attained age 65 before 1968. But some older people who reach age 65 after 1967 cannot qualify under the transitional provision, and the provision itself will phase out as of 1974, as persons attaining age 65 in those years must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

It has become very difficult for many in the uninsured group to obtain private hospital insurance comparable to coverage under medicare. Since the passage of the medicare law, private insurance companies have generally changed their hospital insurance plans available to people age 65 and over to make their coverage complementary to medicare. While there is generally some type of hospital insurance available to persons age 65 and over, most of that which is offered is in the form of specified cash payment insurance for limited periods of hospitalization. Few private health insurance companies offer their regular hospital expense plans to the aged and very little is comparable in protection to that afforded under the medicare program.

Mr. Chairman, Sec. 202 of H.R. 17550 is similar to legislation introduced in the Congress and which was passed by the Senate in the Social Security Amendments of 1967. Unfortunately, the House of Representatives failed to act on this subject and the provision was dropped in conference. We are hopeful that this distinguished Committee will again see fit to report favorably legislation to achieve the goal of adequate hospital protection for the elderly.

On behalf of the National Education Association, I want to thank you, Mr. Chairman, and Members of this Committee, for the opportunity to present the views of our membership on this legislation.

ATTACHMENT 1

State	Membership in State retirement systems for teachers as of June 30, 1969 [1]	Social security coverage	Description of employees not covered
Alabama	48,000	All teachers	None.
Alaska	3,670	None	Full-time teachers, school nurses, principals, supervisors, and superintendents in the public schools; the commissioner of education and professional supervisors within the department of education; and full-time resident professional and administrative staff of tha university designated for membership by the board of regents of the university.
Arizona	[2] 62,435	All teachers	None.
Arkansas	24,305	do	Do.
California	340,281	None (except for certain employees of the San Francisco retirement system).	All public school teachers and other certified employees in the public schools of the State; certain employees in junior colleges; and superintendents and staff.
Colorado	35,898	None	All school district employees, including city of Denver which has its own local retirement system.
Connecticut	41,192	do	Teachers, principals, supervisors, and superintendents; some members employed by the State board of education, the commission for higher education, or any State institution requiring a teacher to hold a certificate.
Delaware	[2,3] 6,000	All teachers	None.
Florida	90,000	By recent law combining the public employees and teachers system, teachers now in service have the option to be covered; all new teachers are automatically covered under the new provision.	At present all 90,000 members are not covered.
Georgia	65,000	On a local option basis; 145 or 195 school districts have social security coverage.	

ATTACHMENT 1—Continued

State	Membership in State retirement systems for teachers as of June 30, 1969 [1]	Social security coverage	Description of employees not covered
Hawaii	[2] 36,445	On a divisional basis; some school employees not covered.	
Idaho	19,796	All teachers	None.
Illinois	120,000	None	All teachers in the elementary and secondary schools of the State, including the city of Chicago; teachers employed in State institutions; and certified employees of the State education department.
Indiana	57,000	All teachers	None.
Iowa	[2] 105,000	do	Do.
Kansas	45,402	do	Do.
Kentucky	35,000	Only teachers in 5 State colleges.	Full-time regular or special teachers, principals supervisors, superintendents, assistant superintendents, attendance officers, and other full-time members of the teaching or professional staff in public elementary or secondary schools for whom certification is required; instructional and administrative staffs of 5 State colleges, and State and area vocational schools; the superintendent of public instruction and certain State education department staff.
Louisiana	45,855	None	Instructional staff, administrators, supervisors, librarians, clerical workers of the public schools (except in New Orleans Parish, which has its own retirement system), deans and teachers in State-supported colleges, members of the State department of education, directors and teachers in State-supported vocational-technical schools, and the secretary and staff of the Louisiana State Teachers' Association and the Louisiana High School Athletic Association.
Maine	[2] 42,519	None	All State employees, all teachers and the employees of political subdivisions covered by the State employees retirement system.
Maryland	50,273	All teachers	None.
Massachusetts	58,100	None	Professional school staff employees who perform service not less than half time as teachers, school psychologists, counselors, occupational guidance and placement counselors; principals, supervisors or superintendents in any public school (except in Boston, which has its own local retirement system), and supervisors and teachers of adult civic education.
Michigan	180,000	All teachers	None.
Minnesota	50,152	Social security adopted for teachers in State colleges in 1957. Social security for other members adopted on divisional basis in 1960.	Examples of members not covered: Certificated members of the Minneapolis public school system and office employees of the local teachers' retirement system, and certificated members of the professional staff of St. Paul public schools; and some employees in State teachers' retirement system.
Mississippi	[2] 79,284	All teachers	None.
Missouri	47,237	None	Full-time teachers, supervisors, principals, superintendents, and other certificated employees of the public schools (except in St. Louis and Kansas City, which have local retirement systems covering public school employees), most State college and State teachers college employees, full-time certificated personnel in the State education department, and certificated members of the retirement system staff.
Montana	12,000	Local option basis; 90 percent of the school districts are covered.	
Nebraska	16,758	All teachers	None.
Nevada	[2] 21,595	None	All public employees, all public school empolyees, and the political subdivisions whose positions normally require 1,200 or more hours of service a year.
New Hampshire	[2] 7,089	All teachers	
New Jersey	95,000	do	None.
New Mexico	21,000	Local option basis. Some teachers not covered.	
New York	174,377	Divisional basis. Some teachers not covered.	
North Carolina	[2] 147,353	All teachers	
North Dakota	9,000	Local option basis. Approximately 83 percent of the teachers are covered.	

ATTACHMENT 1—Continued

State	Membership in State retirement systems for teachers as of June 30, 1969[1]	Social security coverage	Description of employees not covered
Ohio	153,408	None	Teachers and other professional school employees regularly employed in the State, and faculty members at State universities, community colleges, joint vocational and technical schools, and municipal universities; educational employees of the State department of education; and teacher employed in State institutions.
Oklahoma	38,180	Local-option basis. Approximately 92 percent of members are covered.	
Oregon	[2] 69,951	All teachers	None.
Pennsylvania	210,918	Utilized divisional method, own coverage; some teachers not covered.	
Rhode Island	[3] 9,249	Teachers in State schools are covered; local option basis utilized in public school systems.	
South Carolina	[2] 130,109	All teachers	Do.
South Dakota	10,000	do	Do.
Tennessee	42,000	90 percent of teachers covered.	
Texas	257,203	All employees of senior colleges and universities are covered. Local option basis in local public school systems and junior colleges; many teachers not covered.	
Utah	[2] 40,993	All teachers	Do.
Vermont	6,707	Local option basis; some teachers not covered.	
Virginia	[2] 118,000	All teachers	Do.
Washington	43,325	All public school teachers covered. Colleges and universities have separate retirement systems.	
West Virginia	36,711	All teachers	Do.
Wisconsin	59,000	Divisional basis. Some teachers not covered.	
Wyoming	[2] 14,000	All teachers	
Puerto Rico	24,950	None	All teachers in active service and those holding position on the retirement board; administrative personnel in the department of education or in municipalities (except the University of Puerto Rico, teachers employed by the Puerto Rico Education Association; and members of the Legislative Assembly of Puerto Rico holding a valid teaching license.

[1] National Education Association, Research Division; "1969 Teacher Retirement System Summaries," Washington, D.C.: the association, 1969.
[2] Statewide public employees retirement system to which teachers belong.
[3] Estimated.

AVERAGE OF FULL-TIME EMPLOYEES OF STATE AND LOCAL GOVERNMENTS

State	Total number of full-time public employees	Employees with old age and survivor coverage	Percent of full-time employees
Alabama	113,396	99,618	87.89
Alaska	12,344	9,036	73.2
Arizona	63,218	57,888	91.6
Arkansas	62,511	46,392	74.2
California	735,424	296,783	40.4
Colorado	85,071	21,373	25.1
Connecticut	97,682	49,124	50.3
Delaware	37,728	3,189	8.5
District	20,265	15,250	75.3
Florida	233,845	126,171	54.0
Georgia	155,724	109,586	70.4
Hawaii	31,023	25,364	81.8
Idaho	25,703	20,364	79.2
Illinois	366,513	64,550	17.6
Indiana	168,044	142,197	84.6
Iowa	99,363	89,545	90.1
Kansas	88,410	70,453	79.7
Kentucky	99,967	60,241	60.3
Louisiana	138,787	47,214	34.0
Maine	33,060	8,263	25.0
Maryland	137,960	100,842	73.1
Massachusetts	197,257	13,906	7.0
Michigan	301,000	262,820	87.3
Minnesota	128,432	63,967	49.8
Mississippi	77,245	63,392	82.1
Missouri	151,862	97,970	64.5
Montana	26,908	23,500	87.3
Nebraska	57,114	43,095	75.5
Nevada	20,062	595	3.0
New Hampshire	21,851	17,217	78.8
New Jersey	218,122	170,049	78.0
New Mexico	40,616	34,202	84.2
New York	779,661	689,820	96.6
North Carolina	155,602	131,754	84.7
North Dakota	23,757	20,688	87.1
Ohio	324,721	5,233	1.6
Oklahoma	92,531	77,251	83.5
Oregon	78,510	69,676	88.7
Pennsylvania	350,062	793,115	83.7
Rhode Island	30,274	17,403	57.5
South Carolina	79,570	71,824	90.3
South Dakota	27,064	22,675	83.8
Tennessee	140,804	91,696	65.1
Texas	372,406	190,228	51.1
Utah	38,044	33,398	87.8
Vermont	14,348	11,095	77.3
Virginia	148,993	132,680	89.1
Washington	126,339	105,767	83.7
West Virginia	62,359	54,537	87.5
Wisconsin	146,509	129,016	88.1
Wyoming	15,667	14,560	87.4
United States	7,055,000	4,417,000	62.6

Source: U.S. Department of Commerce, Bureau of the Census. Compendium of Public Employment, vol. 3, No. 2, 1967. ashington, D.C., Government Printing Office, 1969, table 17, p. 109.

TEACHER RETIREMENT SYSTEM DATA AND HOSPITAL COSTS, 1969

State	Active members in the retirement system	Total number of retirants	Median per average retirement benefit for all retirants [1]	Average hospital expenses per day [2]	Hospital expenses for a 30-day stay [3]
Alaska	3,670	181	$3,144	$114.30	$3,429.00
California	340,281	37,661	NA	82.63	2,478.90
Colorado	35,898	2,568	1,808	74.98	2,249.40
Connecticut	41,192	4,500	3,777	62.24	1,867.20
Florida	90,000	7,372	3,100	70.98	2,108.40
Illinois	120,000	17,151	2,402	61.15	1,834.50
Kentucky	35,000	5,922	2,336	53.87	1,616.10
Louisiana	45,855	5,839	3,760	56.78	1,703.40
Maine	42,519	7,216	1,973	45.50	1,365.00
Massachusetts	58,100	9,960	3,701	64.79	1,942.80
Missouri	47,237	5,229	NA	59.70	1,791.00
Nevada	21,595	1,992	NA	82.26	2,467.80
Ohio	153,408	25,990	3,240	56.42	1,692.60
Rhode Island	9,249	1,487	NA	62.97	1,889.10
Puerto Rico	24,950	3,955	1,850	56.56	1,696.80

[1] The range in benefits is due to the variation in formulas among the States and the personal employment history of each retirant.
[2] From American Hospital Association, Research Services, Chicago, Ill. Expenses shown reflect costs to institutions, not charges to patients.
[3] Computed from average daily expenses as shown.

The CHAIRMAN. Thank you very much, sir.

We also include the tables that you had submitted here for the record. I think that they are tables which very well document your case.

Mr. MONDANI. Thank you, sir.

The CHAIRMAN. Many thanks.

Our next witness will be Mr. John Doyle Elliott, secretary of the Townsend Foundation.

We are pleased to have you, Mr. Elliott.

STATEMENT OF JOHN DOYLE ELLIOTT, SECRETARY, TOWNSEND FOUNDATION

Mr. ELLIOTT. Mr. Chairman, I am Mr. John Doyle Elliott, secretary of the Townsend Foundation, founded by Dr. Francis E. Townsend, quite a while ago, not exactly a come lately interest in social security legislation.

In summary, the first and most salient thing, we feel, is to keep track of just what has happened to the key group in social security legislation, the elderly retired.

In testimony, as I have submitted to the committee, from the Census Bureau's annual surveys on consumer income, we find that since the end of World War II, starting with 1947 and coming up through 1969, the position of the retired people in the country has, if anything, slightly declined, not improved.

Last year the average elderly man over 65 had an income of $2,828. The average man between 50 and 64, right behind him in life, had an income of $4,451 higher than that. This, inferiority of income is the heart of the whole problem.

We feel very sincerely in our proposed legislation and attitudes and suggestions regarding social security amendments, they are based upon the proposition that this gap, this inferiority of income, this loss of

command of the license to live, money income, is the essence of the whole problem.

Now, nothing has actually been accomplished by all of our legislation, by all of our policies, public and private, group and individual, investment and savings, in this most prosperous period, since World War II of our history, right here; nothing has been accomplished against this.

The ratio between income of these people back in 1947, the inferiority factor was about 145 percent that of their income, and by 1969 it was 157 percent. There is actually an income decline; and when we throw into the picture some of the special things that have been achieved by some groups in a command position, like certain elements of labor, certain positions of people in life, public and private, to command retirement income of a prosperous order, it simply means that for the greater bulk of the population the decline has been more serious in face of the fact that not even a holding of the original line has been achieved.

We, of course, do approve the adoption of any improvements as far as they go, such as the presently proposed House-passed amendments on the ground, and simply on the ground that to go ahead for the next year or two without them would be heaping a very serious injury on top of the original tragedy.

In that sense, of course, we endorse them, but we do not hold them to be any answer, just another ripple in the passing of time, just a repetition of the same failing policy.

I do not know how to put it in a few words, but I think I could leave it this way on that count: what we have been doing and are continuing to do, in action, in policy, in attitude, in viewpoint, is to mismanage the abundance over which we have gained control and command, mismanaging it under the rules, under the views, of scarcity.

It won't work, it has not worked, and we do wish seriously to admonish that what we need is an end of contrasts, an end of discriminations, and I do not know just where we could start if we do not start with this area of the poverty problem in the social security beneficiary area.

There is no sound reason why people living in the retirement years of life, why the standard of those lives and those years should be beneath, at least seriously beneath, the going standard of the rest of the population. It is not to take a nickel out of our national economy or country or its overall life in any week or month or year; it is simply an adjustment process.

Therefore, we suggest legislation which is presently embodied in H.R. 1205 to institute a universal contract in the country which would do for all the people substantially what, for example, the United Auto Workers' program does for the 30-year man. In principle of occupation, not necessarily being in one job, like the 30-year automobile man all his life, but in reality they are all 30-year people, we need a universal contract which will do this job now. Theoretically, old age and survivors and disability insurance, and so forth, might, by a certain analogy, approach that contract, but it would certainly need an awfully lot of fundamental major overhauling to reach or approach that standard.

Therefore, we suggest that the payroll taxes, and so forth, are not the means of doing it, and in my testimony I outline that, but I do suggest that very seriously we recognize that ground has not been gained at all, but fundamentally lost under the policies, programs, views that have been followed. The ground has actually been lost.

There is little sense in talking about ratios between old living standards and wage standards and price standards, cost-of-living standards, unless referred to the original impoverished standard of failure and misfortune economically that lies at the root of this whole problem.

Without taking into account a purpose of remedying that in a major degree, at least, there is not much sense in making the other comparisons. On the whole question, as of 2 years ago, the Special Committee on Aging finally concluded, after several years of hearings and study all around the country, that income lack is the major problem of Americans living in retirement. That remains unchanged, Mr. Chairman, and we respectfully submit the bill and the proposals and this testimony embodying and defining a universal national contract designed and capable of ending that inferiority, H.R. 1205.

In the name of the movement, now over 35 years' old, originally conceiving this viewpoint to start with, I want to thank you very much for the privilege of presenting my testimony in these few moments.

(The prepared statement of Mr. Elliott follows. Hearing continues on page 891.)

TESTIMONY OF JOHN DOYLE ELLIOTT, SECRETARY, TOWNSEND FOUNDATION, ECONOMIC CONSULTANT AND NATIONAL PENSION LOBBYIST

SUMMARY

Mr. Chairman, I am John Doyle Elliott, Sec. of Townsend Foundation, founded by the late Dr. Francis E. Townsend, 5500 Quincy St., Hyattsville, Md., 20784. Since World War II, each Congress has had more broadly to amend the Social Security Act. Now, Congress is amending it in *successive sessions! After 35 years of it.*

It's gratifying, in the last two years, that at long last both House and White House have reversed views and adopted our 35-year-old critique of evil, misnamed "welfare"—and the Senate Committee on Aging has marked *income-lack* "more than ever" the "major problem" of retired Americans, saying only a federal plan can meet it. On each count, now, they thus honor our original key positions and principles.

Now, I call up Census Bureau's yearly surveys on money-income distribution, showing the income-position of the aged *steadily declining—not improving*—despite all our public *and* private works, programs and policies. A total, unanswerable failure.

With the enclosed complete copy of H.R. 1205 (with explaining articles) embodying up-to-date application of the Townsend Plan's principles to the problems of social security and poverty—I present the thesis that it's past high time Congress (and everybody else) turn to a *great, national pension* for ALL Americans equally and alike, providing *PROSPEROUS instead of impoverishing* retirement. Stop mismanaging abundance under the mean, obsolete rules of scarcity.

H.R. 1205 is specifically designed to implement this thesis, including the financial mechanism to support it. All alternatives, fully exhausted, have worse than failed—even failed to prevent the problem's worsening. Authentic FACT despite all earnings, investments and public and private programs—*ALL COMBINED!*

The people and our country's economy and prestige have suffered and lost mightily from this worsening instead of solving problem. In the last three decades, no other investment—economically, socially, or politically—would have benefited the people and profited the country so vastly as this great pension.

Further, I contend, the longer we go without it, the mightier become both the loss and the NEED for the profit which can be gained from no other source, or action.

A system making social security a living fact of life in our land wil not take money out of our economy, or out of the overall lives of honest people, business, or interests—in fact, quite the contrary. *BUT, IT WILL SOLVE PROBLEMS OF THE GREATEST IMPORT—problems not otherwise to be solved—problems which must be solved* if we are to achieve the faith, harmony and unity necessary for the world-inspiring society we ought, by every right, to be.

My testimony also presents steps to amend present Soc. Sec. to help prompt transition to the system we ought to have. Most important, H.R. 1205 provides the specific financial mechanism—financial technology—to implement this matchless contribution towards perfected human prosperity, equality and freedom—*SOCIAL JUSTICE*—the essential demonstration to all Mankind of the incomparable ability and beneficence of our American Way honestly applied.

As a few industries have contracts providing decent retirement for those who've spent their lives with them—I hold it's more than high time we instituted such a contract for ALL our people, in ALL occupations, ALL the time. H.R. 1205 is that contract.

Shall the great mechanisms of science serve man—or man serve the machines?

Mr. Chairman: Our Country, born in a new vision of just freedom and equal rights for all men, inspired world-wide faith and hope in honest hearts. Despite our matchless achievements, the vision's fogged, fulfillment of our promise to God and Mankind faltering by default here in our own national house. I propose through perfected Social Security the ways and means to unfog the vision and resurrect the promise—by fulfillment here in our own land, renewing Mankind's faith and courage by our success.

It's preposterous to expect success against our pyramiding problems and obligations unless dominant confrontations in our land are replaced by the faith and harmony only full social justice *enthroned as unanswerable reality* can ever make possible.

Otherwise, greed, waste and corruption, *the real INFLATORS*, will increasingly decay our material and spiritual resources—ordaining doom. Our skyrocketing producing power must promptly be fully employed, even strained in support of honest prosperity, justice, freedom, health and wisdom—not INFLATING greed, waste and the damning corruption they breed.

Census Bureau's yearly surveys on money-income distribution show Social Security and misnamed "Welfare" monstrously failing to support that necessity. To wit, the FACTS:

MEDIAN INCOME

	Men		Inferiority	(1)	Women		Inferiority	(1)
	Over 65	55 to 64			Over 65	55 to 64		
1947	$956	$2,344	$1,388	145	$551	$962	$411	75
1968	2,652	6,717	4,065	153	1,311	2,576	1,265	96
1969	2,828	7,279	4,451	157	1,397	2,791	1,394	100

Note: Add this fact: Persons over 65 increased in numbers 3.5 times faster than persons 25 through 64, in those same years.

There is the problem—*measured*—growing constantly greater—not being overcome. Steadily deepening *financial depression* for that ever greater part of our adult population—to whose membership all are desirably destined—the elderly. Money-income, the very license to live, is excuselessly denied Americans in retirement. While the final reward in life excuselessly remains financial failure and dependency, *so long will our other works and glories stand vain and mocked* by history's mark of sin.

All our works, policies and programs, *public and private combined*, have failed to prevent the financial plight of the aged *from worsening*—never mind betterment. The median income for men over 65, from 1947 to 1969, rose 196%—while their inferiority to men 55 to 64 rose *221%*. For women the figures are 154% and *239%*. The inferiority of the elderly to still younger adults is even more marked.

Over two years ago, the Special Senate Committee on Aging named income-lack "more than ever" the "major problem" of the old, saying only a federal

plan can meet it. *A full endorsement of this Movement's 35-year-old position.* Last year the Senate passed a $100 minimum Soc. Sec. benefit; killed in Conference. As yet, neither House nor White House has lifted a finger. Pray the Senate requires a very meaningful raise.

The elderly's financial misfortune is duplicated for the disabled, for families bereaved of natural breadwinners and for those mentally and physically *competent* who are unemployable because the changes of history and progress render their skills unworthy of hire. They are unjustly misfortuned by mismanagement of the very progress which so wondrously benefits most of us—and so richly promises a posterity.

Last year's 15% Soc. Sec. benefit raise and the contemplated 5% will make but a passing ripple, like their predecessors. Proposed national standards for Welfare hint commendable awakening—*30 years late!* It's ironic that every *delinquently mean penny* of such overdue "improvements" is avidly precious to the hungered victims of our feeble policies. No decent heart can deny them the pittance, now.

But, in no sense can they contribute to the *full justice* on which depend the faith and harmony we must have. For that they are less competent than were the original enactments and their long list of amendments to them, in their times.

The plan we need exists. To discern it, you need only examine what the *difference* would be *IF*, somehow, *we'd never encountered the problem.* No elderly, no disabled, no bereaved families would be in poverty. Those whose skills technology's changes make unworthy of hire would be protected—pending their acquiring needed abilities.

It's self-evident—had we never encountered the problem, that happy prosperous state for the people and the country would be "costing" dollar for dollar exactly what an honest plan to wipe out the evil would cost. "Cost" is relevant only in the sense of measuring the value of the benefit AND of the loss from the evil. "Cost" is irrelevant in the sense of burden, or loss; but, it's fully relevant measuring a highly profitable, prospering investment for every honest, human interest.

That difference between how things are and how they ought to be and would be *if* we'd never met with the problem—that difference meticulously defines, measures and spells out *what's necessary to fill the gap*—to change the shaking society around us to the happy, unchallengeable America which should exist by every good reason.

No project, no investment can so mightily profit us and all mankind so much as filling that gap. The priceless prize of peace unanswerably requires it.

One thing can wipe out that gap—a great, national pension sufficient to bar poverty even for those caught with no other resource—as the equal, inherent right of every American in retirement, or encountering any of the other misfortunes noted above. The injustice which only just Soc. Sec. benefits can wipe out is authentically *measured* by the Census Bureau data above. Today, that pension would have to be over $300 a month. *The measure of the shaking, evil problem we harbor.*

The great pension is the one thing which could have made the difference in the past. It's the ONE THING which ever can. Without it, the inferiority of the old and others will remain and grow—the forebodings of the Riot Commission come to pass. Without it we can spend trillions to rebuild rotted cities—only to populate them with paupered legions, making future slums out-horroring the most nightmarish imaginings.

Mr. Chairman, I anxiously adjure we must have a drastically reformed, freedom and equality reflecting *definition* of the so-called poverty-line. Medicare recognizes you can't relate treatment to wage-records—*you can't give somebody half an appendectomy!* Poverty exists unless a person can reasonably finance fully healthful diet, respectable clothing and housing, full medical and health insurance and care (including preventive needs)—and normal participation in recreational, social, cultural and public life and affairs. A *whole,* not *part* treatment on these counts, too!

Lacking this minimum participation in up-to-date prosperity—the minimum requirements of freedom and equality are financially precluded—and all other works in vain.

The great pension must be a floor of prosperity below which we won't allow human living because of financial lack—with earnings deducted so the benefit exhausts close to the up-to-date average. We mustn't hang people under a poverty-ceiling (as proposed) to which earnings barely raise them from a benefit-base deep in poverty, leaving them in its mire. *We must prevent people getting down to actual poverty.*

I condemn poverty-perpetuating proposals—like $1,600 a year, per family of four, $1.10 a day per person—to taper off after they've $1,000 additional, up to a poverty-ceiling of $3,500—$2.50 a day per person. *It costs us $2.50 a day to board our cat while away from home.* Cat-and-dog pensions for American people—sickening brutality misnamed welfare" *and Social Security, too. Thirty years obsolete!*

In contrast, the Federal Minimum Wage is $1.60 an hour, about $275 a month on a 40-hour week. Up-dated, it's over $300 a month—to keep an individual fit to work—*over $3,600 a year,* in Congress' own conscience. The lease for which we can conscientiously use the time, life of another for our benefit, or profit, *according to Congress' own conscience.* What justice reduces it 75% on retirement?

Per capita income, average "cost" per human life, cradle to grave, is comparable. How can we condone less for retired and disable adults? I've heard no answers.

Wrong are bills to raise the payroll tax-base up even to $15,000 (top benefits over $500 a month). So to obligate the public purse to match retirement contributions for the prosperous is excuseless. All the old objections falsely raised against living benefits for the misfortuned *apply fully to this public aid to the well-to-do.* We have the problem because of the misfortuned—not because of prospering people!

Use of "G neral Revenue" would be equally wrong—in lieu of exorbitant payroll taxes. To tax progressively for general government cost is fair (tho' in practice betrayed). So to finance benefits is to *heap progression on progression*—defenseless.

By the great pension in H.R. 1205, under flat-rate contributions by all, the poor will pay the least, but benefit the most. The prosperous will pay the most with the benefits meaning progressively less to them. A progressive benefit to the poor.

The great, national pension I advocate, fully defined and provided by H.R. 1205, is not a Government-spending—it is a people-spending program! It is a universal contract financially involving all our people, all occupations, all business and industry and all contracts and transactions all the time—to provide for all the people alike just about what the auto industry contract does for the 30-year man there.

This will take no money out of our economy, or out of the overall lives of honest people, honest business, or honest interests. It will benefit all, over and above its direct beneficiaries, by the greater prosperity which will prevail—and by the relief from the costly problems resulting from social injustice, now. It will end the dividing discriminations inherent in misnamed welfare and Social Security, now.

Without this achievement, we can never enthrone as unanswerable reality the full faith and harmony necessary for fulfilling our country's promise to Mankind.

NOTE that Administrative costs will be nothing, because we are already more than paying them now for the feeble, unjust, complicated system we have. In truth we are paying for a 1970 Cadillac—but we're getting a Model-T ride for our money!

Contrasts.—Discrimination is an evil thing. As the Supreme Court said, ". . . inherently un-Constitutional." Just get old, or disabled and its *real meaning's cruelly taught.*

Last year's 15% Soc. Sec. raise, plus the contemplated 5%, compound to 22% over not less than two years. In terms of an 8-hour day, a 40-hour week, *it's about 13 cents an hour raise*—with no overtime, no extras.

In contrast, we've seen teamsters settling for $1.25 an hour (not 13 cents!), over 3 years N.Y. printers about $1.40 an hour—Chicago truckers $1.85. Contrast!

How can Congress and the Nation stomach such savage discrimination?

Everybody with the power to grab—economically able to blackmail the public—seems grabbing grand pensions. Everybody who, in truth, is best able to provide for themselves. Walter Reuther left the UAW's primed to require $500 monthly pensions for 30-year auto workers. Whatever they actually get will make misnamed Soc. Sec. look prehistoric—and other unions capable of the pressure will follow. Contrasts!

We recently read of a railroad's top executive, outsted as the road faces bankruptcy in history's most prosperous time and place—we read of his $114,000 a year pension. Then, we read it's a mistake—he's only—*only*—good for $50,000! His salary's only been about $225,000 (plus a lot of extras), so he couldn't provide

for his own retirement, $50,000, in terms of an 8-hour day etc., comes to about $192 a day, $24 an hour—alongside $6 a day, 1/32d as much, for the average Soc. Sec. retiree.

Which could reasonably finance his own retirement—and which is the big grabber of something for nothing?

What about professional footballers—asking for pensions up to $100,000? In public life, too, the big pensions go to the most prosperous.

Those most properly able to finance their own retirement—who've the best means for saving, investments etc. are greedily exerting economic pressure on their country for exorbitant pensions. The great majority of Americans, especially average people and outstandingly the misfortuned, are getting crusts and crumbs. Who *IS* on relief????

This is self-evident—and if not ended will doom faith and harmony in our society. The grand pensions, seized by the powerful, *are not out of their wages*. They are in *addition—out of the public pocket via prices, via taxes, graft and corruption*—for those with no excuse at all for being on relief. And that's what it is.

Every argument, urged so falsely for over 35 years against decent, living pensions for Americans generally and most fully for the misfortuned—every one applies unanswerably to these undeserved gifts from the public purse to the well-to-do. Lord!

Living pensions, reflating the deflated lives of the misfortuned—keeping up to date the lives of Americans generally—these are not inflationary. The extravagant undeserved, needless gifts to the rich, these are highly inflationary! For example.

Mr. Chairman, to have faith, harmony and unity replace the confrontations smashing our society today, without that great pension, is starkly unthinkable. Dishonest mismanagement of our abundance by the obsolete, tyrannous rules of scarity must stop. Greed has no further claim on such excuseless benefit! Otherwise, all our achievements stand shamed by failure to serve God's Will and justice to Mankind.

In truth, the mightier our achievements and progress, the less excuse—and the worse every reason—for tolerating avoidable injustice and human woe. Poverty and it's deflation—greed, corruption and their inflation—they must go. The great pension is the sine qua non of their demise.

What must be done is vigorous transition to the great pension for the old and other unemployables, which will wipe out evil discrimination by equal, honestly sufficient Soc. Sec. for all, equally and alike.

H.R. 1205 provides direct transition from our present system to the great, national pension, swiftly. There is an indirect approach to the same goal, which is the very least conscientiously to do now for discontinuing the evils sapping our strength.

Vest in every person equally an *assumed* "wage in covered employment" sufficient for a retirement benefit of $175 a month. With this *one program* for all, alike, welfare and public assistance—except in very rare, extreme cases—and Soc. Sec. benefits to most adult dependents will cease. Periodically advance this minimum benefit until it bars poverty even for those caught with no other resource.

Adjust benefits in step with per capita income reflecting changes not just in living costs, but all monetary changes, annually.

Suspend earnings limitations until benefits, regardless of other assets, bar poverty.

Make retirement age 60. Cover technologically and educationally disabled over 18.

Finance transition not by payroll tax hikes, or piling up general revenue taxrates. Use the gross receipts tax defined and provided in H.R. 1205. Free State and local governments from welfare and public assistance costs and evils.

Remove medicare limitations, including deductibles and premiums. Include chiropractic physicians. Cover all Soc. Sec. beneficiaries, as well as the aged.

Provide retirement and disability bonds, appreciating with per capita income, for all wanting to amplify retirement finance without traditonal investment risks.

This is not just a plan. It's the plan. Without the very things it both defines and provides, the most fundamental frustrations and injuring injustices causing our country's divisions will remain in force, rampant and mounting. Without it, *trillions* will be spent to rebuild rotted cities—and to pack populations into vast suburbs until they become equally vast cities themselves—so spend *trillions* only

to inhabit them with paupered legions, ordaining future slums out-horroring any nightmare. However titled, any step to correct any of these most basic wrongs will have to be part of this specific plan—*since, indeed, it has been defined and recorded.*

Truth is we must have prosperous—not paupered—retirement equally provided for all in the same way. So, too, for the other areas, both permanent and correctible, of disability and unemployability. It's time for real answers to problems.

Time's run out, Mr. Chairman, for tolerating things wrong—for callously gradual, too often fictitious, ground-losing "steps in right directions". The great, massive strike of swift, decisive, *achieving action* looms as the total necessity. I very respectfully admonish *this plan's to that end the primary essential—sine qua non.*

To what end save cities—or work any great wonders—unless we save the humanity for whose freedom and betterment all things economic exist?

We will successfully conquer no physical pollutions while we tolerate perpetuation of the moral pollutions of injustice—tolerate the exploiting greed, corruption and the crime they breed which have perpetrated, created our physical pollution.

It many well be that Mankind cannot reform its character—but, it had better very soon control and remedy its conduct—which we can do, by contract, law enforced. The fundamentals of that contract, law, are defined and provided in H.R. 1205; and implementation, transition presented in this testimony.

Progress ad abundance are mismanaged when they bring hurt to anybody—and if they fail to provide bettered, not problem-plagued economic and social life for all.

Without the great pension, these truths and our country's promise to Mankind can't be honored and fulfilled.

INCOME-INFERIORITY OF THE AGED

MEDIAN INCOMES

	MEN				WOMEN			
	Over 65	55 to 64	Inferiority	Inferiority as percent of income of those over 65	Over 65	55 to 64	Inferiority	Inferiority as percent of income of those over 65
1947	956	2,344	1,388	145	551	962	411	75
1948	998	2,412	1,414	142	589	857	268	46
1949	1,016	2,366	1,350	133	516	1,000	484	94
1950	986	2,494	1,508	153	531	918	387	73
1951	1,008	2,840	1,832	182	536	968	432	81
1952	1,247	3,009	1,762	141	654	1,175	521	80
1953	1,150	3,271	2,121	184	659	1,170	511	78
1954	1,268	3,195	1,927	152	694	1,195	501	72
1955	1,337	3,440	2,103	157	700	1,257	557	80
1956	1,421	3,567	2,146	151	738	1,364	626	85
1957	1,421	3,681	2,260	158	741	1,342	601	81
1958	1,488	3,968	2,480	167	776	1,326	550	71
1959	1,576	4,190	2,614	166	797	1,431	634	80
1960	1,698	4,289	2,591	153	821	1,415	594	72
1961	1,758	4,597	2,839	161	854	1,480	626	73
1962	1,910	4,800	2,890	151	920	1,669	749	81
1963	1,993	4,901	2,908	146	920	1,774	854	93
1964	2,037	4,941	2,904	143	952	1,910	958	101
1965	2,116	5,250	3,134	148	984	2,019	1,035	105
1966	2,162	5,750	3,588	166	1,085	2,214	1,129	104
1967	2,304	6,122	3,818	166	1,123	2,352	1,229	109
1968	2,652	6,717	4,065	153	1,311	2,576	1,265	96
1969	2,828	7,279	4,451	157	1,397	2,791	1,394	100

Note: Add this fact: Persons over 65 increased in numbers at a rate 3.5 times that of persons aged 25 through 64.

There are the facts. Remember the above reports money—income from all sources—all.

Source: Census Bureau, Current Population Reports, 1947–1969, Series P–60, No. 5, Table 15; 6–12; 7–17; 9–18; 11–3; 14–3; 16–3; 19–3; 23–3; 27–18; 30–18; 33–24; 35–23; 37–23; 39–25; 41–18; 43–20; 44–6; 50–2; 52–6; 60–3; 63–6; and 70–6.

The income status of the elderly has not improved—netting, if anything, a slight loss. But, that's not all of it. A few in certain groups, like auto workers, for example, won themselves better pensions. But, since the aged, as a whole

didn't gain, the good gains of these scattered groups *means the rest generally lost, all the more!* Keep that truth in mind.

In that light study the above "Inferiority' Column and you'll see how all the programs and policies, public and private combined, have failed the aged—and how only our Bill can provide them the very license to live, money-income. Only our Bill.

It is very far past high time we had prosperous retirement—a "contract" for *all* the people, *all* the time—just as validly as contracts in the auto' and other industries exist for some special few. H.R. 1205 is that contract, universally covering all, all the time, in every occupation and in every business.

The burden of proof should now rest on those who'd still insist on foolishly trying to make the demonstrably unworkable old system work—and you'll find *every reason they'll give will be a bad one!* There isn't and *there never has been any good reason* for living standards in retirement being impoverished, or in any way inferior to the earlier periods of adult life.

The CHAIRMAN. Thank you very much, sir. Your entire statement has been placed in the record and will be printed, as well as your verbal presentation.

Mr. ELLIOTT. Thank you, sir.

The CHAIRMAN. The next witness we will call will be Mr. Alan F. Charles, National Legal Program on Health Problems of the Poor.

STATEMENT OF EDWARD BERLIN, WASHINGTON COUNSEL, NATIONAL LEGAL PROGRAM ON HEALTH PROBLEMS OF THE POOR

Mr. BERLIN. Mr. Chairman, unfortunately, Mr. Charles could not be here today, and he asked me to be here in his place, if it meets with your approval.

My name is Edward Berlin, and I am a member of the law firm of Berlin, Roismen & Kessler, the Washington representative, Washington Counsel, of the National Legal Program on Health Problems of the Poor.

I recognize the time limitations that you are operating under, Mr. Chairman, and if it would be agreeable with you we would prefer to submit the entire prepared statement for the record and very briefly summarize the more salient points made within that testimony.

I should also like to submit, at least for the committee's files, a Law Review article which has recently been prepared by Mr. Silver, who is the director of the National Legal Program on Health Problems of the Poor, and which is soon to be published in Law and Contemporary Problems.[1]

Mr. Chairman, I know I need not dwell on the fact that the delivery of medical services, particularly in-hospital services, is increasingly coming under attack from all quarters.

One of the questions before this committee is how are the existing problems to be addressed. We are convinced that there is one area in which reformation is essential, and that is in the regulatory sphere.

In essence, the quality of care in the Nation's hospitals is currently regulated in one of two ways:

First, at the State level under licensing acts which do little more than impose standards governing the construction and operation of hospitals. They rarely are concerned with matters that deal with quality of service.

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[1] The article was made a part of the official files of the committee.

The second means by which hospitals are regulated is pursuant to standards established by accreditational bodies. Of these bodies, one, the Joint Commission on Accreditation of Hospitals, has national recognition and its scope is wide indeed. It is a private body, as you know Mr. Chairman, composed of representatives from six organized segments of American medicine; the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons, the American Association of Homes for the Aging, and the American Nursing Association.

The CHAIRMAN. If I might just ask you to suspend, I am going to try to answer that rollcall vote that is going on now, I will be back as soon as I can vote.

(Short recess.)

Senator ANDERSON (presiding). Mr. Berlin, continue with your statement, go right ahead.

Mr. BERLIN. Mr. Chairman, the joint commission inspects hospitals on a voluntary basis and grants accreditation based upon compliance with standards of hospital adequacy which it has established. Unfortunately, the standards are far from being completely satisfactory.

Unfortunately, too, the Joint Commission on Accreditation procedures have become pro forma.

The difficulties of Joint Commission Accreditation are accentuated when recognition is given to the fact that its actions automatically lead to certification under medicare. This must end. The joint commission is a private body responsive to the needs of its members and not necessarily representative of the interests of the hospital patient.

Although the joint commission thus may fail to be accountable to the public, its standards have been imposed as ceilings for hospitals participating in medicare. These are not minimum standards nor even suggested maximum standards, but maximum mandatory ceilings.

The voting members of the joint commission could decide to ignore the interests of the public, and yet the Secretary would be powerless to do anything about it.

For these reasons, the Health Insurance Benefits Advisory Council has strongly urged that medicare certification standards no longer be controlled by the joint commission but rather by the Government.

It has recommended, and we strongly endorse its suggestion, that the Secretary be given the authority to establish health and safety standards for hospitals, leaving with him the authority, in the case of any national accrediting body which has standards and certification procedures equal to or higher than those which he may establish, to find that such accreditation provides reasonable assurance that the conditions of participation are met.

In any event, a further amendment to section 1865 is essential.

At most, approval by the Joint Commission on Accreditation should constitute only prima facie evidence of compliance with the conditions of participation, and further, the Secretary should be authorized to require that the conditions of participation be met even by hospitals which already are accredited by the Joint Commission.

Let me make one final suggestion. There is a definite need for some sort of mechanism by which patient and staff complaints can be considered. Recent requests by hospital staff members for hearings in

which they could present evidence under section 1007 of the regulations promulgated by the Secretary, evidence directed at establishing that the hospital had deficiencies "of such a character as to seriously limit the capacity of the institution to render adequate care or which place health or safety of individuals in jeopardy," have been denied both by State agencies and by HEW on the ground that accreditation by the Joint Commission precluded application of section 1007 of the regulations.

No other provision in the statute or regulations allows for a hearing. This should be remedied by making explicit provision in the statute for a mechanism by which evidence may be submitted to the Secretary by consumers and hospital staff regarding either certification or decertification. Where appropriate information is furnished to the Secretary he should be required to invoke the section 1007 procedures.

The provisions should require that the Secretary make explicit findings on the evidence presented to him, should apply regardless of Joint Commission Accreditation, and should make such accreditation only prima facie evidence of compliance with the condition of participation.

Mr. Chairman, the remainder of our prepared statement is addressed to the suggestion that section 1903(e) be repealed.

We strongly urge the retention of that section. As you know, Mr. Chairman, it represents a clear congressional declaration of the right of all citizens to comprehensive health care and services. To be sure, that declaration is far from being realized, and many will argue, no doubt, that its repeal would have little effect. We beg to differ.

To rescind that declaration to any extent would be to break faith with an unfortunately large segment of the American population.

We urge you to maintain their faith in the dedication of the Congress to see to it that every American enjoys an appropriate level of medical care.

Thank you, Mr. Chairman.

(The prepared statement follows. Hearing continues on page 903.)

Statement of By Laurens H. Silver, Director, National Legal Program on Health Problems of the Poor

I

THE ROLE OF JCAH IN HOSPITAL MEDICARE CERTIFICATION MUST BE REASSESSED IN LIGHT OF HBIAC RECOMMENDATIONS

Many of those among the nation's elderly and poor who require hospital care are treated in our public hospitals. Although regulatory bodies presumably ensure the maintenance of minimal professional standards in these institutions, the quality of care they in fact provide is almost universally acknowledged to border on the abysmal. That the regulatory agencies have thus failed in their task is obvious. That the Congress of the United States, by amending existing legislation, can set about rectifying that failure is what I intend to demonstrate today.

The quality of care in the nation's hospitals is currently regulated in two ways:

First, at the state level, licensing acts establish agencies responsible for setting and enforcing standards to be met by hospitals operating within the state. These state regulations have largely failed to treat the area of "quality of care" with any degree of adequacy, and have not, moreover, been enforced with much vigor.

The second means by which hospitals are regulated is pursuant to standards established by accreditational bodies. Of these bodies, one—the Joint Commission on Accreditation of Hospitals (JCAH)—has national recognition and ex-

tensive application. The JCAH is presently a private body composed of representatives from six organized segments of American medicine: the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons, the American Association of Homes for the Aging, and the American Nursing Home Association. It inspects hospitals on a voluntary basis and grants accreditation based on compliance with "standards" of hospital adequacy which it has established. Unfortunately, these standards are far from being completely satisfactory. The very latest standards, approved in April, 1970 and due to become effective January 1, 1971, fail to prescribe requirements for out-patient services, fail to consider the adequacy of the hospital staff to meet the patient load, do not articulate a clear responsibility on the part of the hospital to serve its community effectively, do not consider the rights of the patient with regard to such problems as subjection to experimentation and participation in clinical teaching programs, and ignore the question of quality of care "output" (i.e., the substantive findings of patient care). Further, the standards do not specify what constitutes substantial compliance with the standards for the purpose of accreditation.

There is a third means by which American hospitals are (or, more precisely, *might be*) regulated, and that is through federal review. At present, however, this route is almost wholly ignored. The role which might be played by the federal government has gone by default to a private body, the JCAH, with the unhappy results of which we are all aware. In 1965, when the federal Medicare program was adopted, Congress chose to look to JCAH accreditation as the primary means of certifying a hospital as a provider under Medicare. Section 1861(e) of the Social Security Act of 1965, 42 U.S.C. § 139x(e), sets forth certain minimal requirements to be met by hospitals seeking reimbursement for services rendered to Medicare beneficiaries. It also empowers the Secretary of Health, Education and Welfare (HEW) to establish "such other requirements as [he] finds necessary in the interest of the health and safety of individuals . . . furnished services in the institution," *but* these "may not be higher than comparable requirements prescribed for the accreditation of hospitals by the (JCAH)." The statute thus adopts the inadequate standards promulgated by a private agency, controlled by physicians and hospital administrators, as the *upper limit* which the Secretary can demand. In this way, the federal government has been effectively prohibited from upgrading through the Medicare program the quality of care provided in the nation's hospitals. Once a hospital is accredited by the JCAH, no independent inspection or evaluation is even ordered by the government; JCAH accreditation is tantamount to statutory approval of the hospital for reimbursement as a Medicare provider. (42 U.S.C. § 1395bb.)

Unfortunately, the JCAH accreditation methods are to a large degree ineffective and have led to a tendency toward pro forma reaccreditation. This is demonstrated by the fact that in 1968, of 130 state and local governmental hospitals registered with the American Hospital Association, 128 were accredited. Included among the latter were D.C. General Hospital, Boston City Hospital, and such other problem-ridden institutions as Cook County Hospital in Chicago and Newark City Hospital. All but the last have come under public scrutiny in recent months regarding the deterioration of patient care and staffing. The fact that such institutions are accredited despite obvious and admitted deficiencies attests to the inadequacy of the standards applied by the JCAH and the ineffectiveness of the accreditation program in maintaining hospital quality.

Of course, not all hospitals wishing to participate in Medicare are JCAH accredited. Those without accreditation must be inspected to determine their compliance with federal "Conditions of Participation", issued by the Secretary of HEW. The results of these inspections (carried out in most states, under current HEW practice, by the state hospital licensing agency rather than by federal inspectors) are similarly ineffective, if their goal is to monitor hospital quality. "Substantial compliance" with the federal conditions in sufficient for certification (20 C.F.R. §§ 405.1002, 405.1005), while hospitals failing to meet even this broad test can yet qualify under a special "access" certification category (20 C.F.R. § 405.1010) or be reimbursed by HEW for emergency services although unable to be certified in any category (20 C.F.R. § 405.1011). Recent data indicate that as of June 30, 1970, there were 1,704 hospitals having deficiencies but certified as providers, while another 411 were given special "access" certification. Thus 25% of the 6,799 certified hospitals are not fully in compliance with the federal conditions of participation.

The reliance of Medicare certification upon JCAH accreditation, by which accreditation automatically leads to certification as a Medicare provider, must end. JCAH is a private accrediting body responsive to the needs of its members and in no way represents the interests of the hospital patient. Although the JCAH thus fails to be accountable to the public, its standards have been imposed as *ceilings* for hospitals participating in Medicare. These are not minimum standards, nor even suggested maximum standards, but mandatory *ceilings:* requirements established by the Secretary of HEW "may not be higher than comparable requirements" prescribed by JCAH. This makes no sense whatsoever: in setting accreditation standards, the voting members of JCAH—doctors and hospitals—may decide to ignore or slight the interests of the public in favor of their own interests, and yet the Secretary is powerless to make any changes in favor of the public and to require higher standards as a condition for reimbursement under Medicare.

For these reasons, the Health Insurance Benefits Advisory Council has strongly urged that Medicare certification standards no longer be controlled by the JCAH, and that policy both on setting and enforcement of minimum quality standards be set by the Government. (Health Insurance Advisory Council, *Annual Report on Medicare, 1966–1967,* p. 9.) The Council recommends amendment of the law to remove the limitations on the Secretary's authority to establish health and safety standards for hospitals, presently found in Section 1865, so that:

(1) The Secretary would have the authority to establish health and safety standards for hospitals commensurate with his authority to establish such standards for other providers of services and for independence laboratories, and

(2) The Secretary may, in the case of any national accrediting body with standards for other providers of services and for independent laboratories, *lished by the Secretary* for a class of providers or independent laboratories, find that such accreditation provides reasonable assurance that the conditions of participation are met. (Recommendation 3.)

A further amendment to Section 1865 is essential. As I have already noted, the Secretary of HEW is granted authority by that section to establish "necessary" requirements for hospitals, and he has in fact issued detailed regulations pursuant to that authority as "Conditions of Participation for Hospitals," 20 C.F.R. § 405.1001 *et seq.* These conditions at present are applicable, however, only to hospitals which are *not* JCAH-accredited. (You will recall that once a hospital has JCAH accreditation, the federal government requires nothing more of it.) The present law permits such abuses as automatic certification of a hospital accredited at some time in the past and not due for another JCAH inspection until some time in the future. The statute should be amended to provide that JCAH accreditation shall constitute only prima facie evidence of compliance with the Conditions of Participation, and to authorize the Secretary to require that the Conditions of Participation be met even by hospitals which are already accredited by the JCAH.

The statute should also be clarified in another respect. Its present language can be interpreted to permit the Secretary to issue standards in areas not covered by the JCAH (i.e., non-"comparable" standards). The Secretary has not chosen to interpret it in this way. Revision of this language to make clear the Secretary's authority and to extend it to accredited hospitals, as well, is required. As a result of these changes, the Secretary would be guided to some extent by the JCAH standards, but he would also be free to develop his own.

A final suggestion for legislative change involves the need for some sort of mechanism by which patient and staff complaints can be considered. Recent requests by hospital staff members for hearings in which they could present evidence under Section 1007 of the Regulation (20 C.F.R. § 405.1007), to prove that the hospital had deficiencies "of such a character as to seriously limit the capacity of the institution to render adequate care or which place health or safety of individuals in jeopardy," have been denied both by state agencies and by HEW on the ground that JCAH accreditation precluded application of Section 1007. No other provision in the statute or regulations allows such a "hearing". This should be remedied by making explicit provision in the statute for:

(1) a mechanism by which evidence may be submitted to the Secretary by consumers and hospital staff regarding either certification, or decertification by the Secretary under § 1007; and

(2) a mechanism providing for a proceeding under § 1007 upon receipt of adequately documented consumer and/or staff complaints.

These provisions would require the Secretary to make explicit findings on the evidence presented to him, would apply regardless of JCAH accreditation, and would make such accreditation only prima facie evidence of compliance with the Conditions of Participation.

These amendments to the current Medicare program can thus mean improvement in the quality of care provided in the nation's hospitals, not only for the elderly, not only for the poor, but ultimately for all of us.

II

WE URGE THAT SECTION 1903(e), MANDATING COMPREHENSIVE SERVICE TO MEDICAID RECIPIENTS, NOT BE REPEALED

Section 228 of the Social Security Amendments of 1970, proposed by H.R. 17550, would repeal Section 1903(e) of the Social Security Act, 42 U.S.C. § 1396b (e). The National Legal Program on Health Problems of the Poor views this amendment with great concern and would like to express its strong opposition to the proposed repeal of § 1903(e).

The purpose of Title XIX of the Social Security Act was, in the words of the Act,

". . . to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, . . ." 42 U.S.C. § 1396.

Congress left no doubt about its goal of providing *comprehensive services to substantially all of the needy* through Title XIX nor about the seriousness with which it viewed that goal.

Congress provided that,

"The Secretary shall not make payments . . . to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance with a view toward furnishing by July 1, 1975, *comprehensive care and services* to *substantially* all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care." 42 U.S.C. § 1396b(e).

Even with the extension from 1975 to 1977 at which time all State Medicaid programs must provide comprehensive medical care to substantially all needy, Congress has continued to support the original goal of the 1965 legislation. The proposed amendment, elimination of Section 1903(e) in its entirety, is a rejection of that goal, and would, in the opinion of the National Legal Program, vitiate the most important medical care program for the poor in the United States.

Why Medicaid? Why should the Federal and State governments support a comprehensive health service program for the needy? The basic premise upon which the Medicaid program was enacted was that health care for all Americans is a basic right and not a privilege. Medicaid became an indirect medical service program for the needy because the needy had no other way in which to secure the right of health care, and the poor suffered--and continue to suffer—from more morbidity and mortality than the non-poor. But to what extent are the poor beset with health problems?

It is well known the number of chronic disease conditions and the annual experience of days per person of restricted activity, bed disability and time lost from work are markedly greater for persons with low family incomes than individuals with average or high family incomes.[1]

Sixteen poverty areas were identified in 1961-1963 in New York City on the basis of low income and frequency of social problems. Table I shows several of the health problems of these neighborhoods compared to the rest of the city: a sixty per cent excess of infants who died in poor versus non-poor areas; women who received postponed or no prenatal care during pregnancy and women who died during childbirth experienced more than twice the expected city rates; infectious syphilis was three times as great in poor areas; and low-birth weight babies in poor areas were 1.6 times as frequent as in the remainder of the city. When it is realized that fewer older individuals reside in poor communities than other areas, the percentage excess of crude death rates (such as tuberculosis, diabetes and pneumonia) tends to widen not diminish.

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[1] Bergner, L. and Yerby, A. S. "Low Income and Barriers to use of Health Services" New Eng. J. Med. 278: 541–546, 1968.

TABLE 1.—NEW YORK CITY, HEALTH OR SOCIAL PROBLEMS IN POVERTY AREAS, 1961-63 [1]

Problem	Total	16 poverty areas	Rest of city	Percentage excess of poverty areas over other areas
Maternal mortality per 10,000 live births	7.3	11.8	5.0	136
Infant death rate per 1,000 live births	26.2	34.8	21.8	60
Percentage of mothers receiving late or no prenatal care	22.3	38.4	14.0	174
Percentage of live born infants weighing 2,500 gm or less	9.7	12.7	8.2	55
Percentage of births out-of-wedlock	10.5	20.3	5.3	283
Cases of infectious syphilis per 100,000 population	95.6	206.7	51.8	299
Crude death rate per 100,000 population:				
Tuberculosis	9.3	15.3	6.9	121
Diabetes	22.6	23.4	22.3	5
Pneumonia and influenza	44.5	53.5	41.0	30
Home accidents	12.3	13.7	11.8	16

[1] Data from statistical division, Department of Health, city of New York.

Immunization is a most important preventive measure in the abatement of communicable disease. Again in New York City, in 1964, studies revealed extreme differences in terms of family income between immunization status of children one to four years of age (see Table 2).

TABLE 2.—FULL IMMUNIZATION OF CHILDREN 1 TO 4 YEARS OF AGE ACCORDING TO FAMILY INCOME AND TYPE OF IMMUNIZATION (NEW YORK, 1964) [1]

Family income	Percentage fully immunized		
	Diphtheria, pertussis, and tetanus	Poliomyelitis	Smallpox
Up to $1,999	50.7	23.9	44.8
$2,000 to $3,999	64.5	40.1	69.1
$4,000 to $5,999	77.7	55.4	85.1
$6,000 to $7,999	82.5	63.1	87.8
$8,000 or more	90.6	66.0	92.6

[1] Adapted from: Immunization status of New York City population under 30 years of age, 1964 (New York City Department of Health).

It is important to note that the New York experience is not unique. In surveys undertaken by the National Center for Health Statistics, U.S. Public Health Service, it has been clearly documented that health stataus varies inversely with family income throughout this nation. For example, for persons under 65 years of age in families earning less than $3,000 the rate of visual impairments was 36.8 per 1,000; the rate dropped considerably to 11.3 in families earning $10,000 or more.[2] The rate of hearing impairments for persons in the sub-$3,000 income bracket was 90.0 per 1,000, while the rate in the $10,000 and over income category was 32.4 per 1,000 [3]—about a three fold increase. With family income less than $3,000 the prevalence of speech defects is 10.6 per 1,000, and that rate drops to 4.8 per 1,000 when family income increases to $10,000 and over.[4] Even after standardizing for age, hearing impairments were twice as prevalent in the sub-$2,000 income group than in the $7,000 income bracket. In the 65 years and over category, the rate was 50% higher for the low income group.

The incidence of many forms of cancer, taken together, varies inversely with income. In a study comparing the sex, age, and race specific incidence rates of 21 types of cancer with income class, it was found that most types varied inversely with income class, several showed no relationship, and only one type—breast cancer—varied directly.[5] In the same study it was found that the pro-

[2] National Center for Health Statistics, U.S. Dept. H.E.W., Public Health Service, "Medical Care, Health Status, and Family Income, U.S.", Series 10, No. 9 (Government Printing Office, Washington, D.C.) May 1964, p. 2.

[3] *Ibid.*, p. 34.

[4] *Ibid.*, p. 38.

[5] Dorn, H. F. and Cutler, S. J. "Morbidity From Cancer in the United States," Public Health Service Publication No. 590, U.S. Dept. H.E.W. (Government Printing Office, Washington, D.C.) 1959, pp. 91–100.

portion of reported and diagnosed cases while still at the localized (and more treatable) stages varies directly with income; that is, poorer individuals were more likely to have their cases diagnosed at later, more serious stages.[6]

As noted above, the likelihood that those who have a chronic condition associated with an inability to carry on a major activity varies inversely with income. The age-adjusted rate for persons limited in carrying on a major activity due to a chronic illness was 10.7% in the group earning less than $3,000 and 4.1% of those earning $10,000 or more. The respective proportions in the same income categories unable to carry on a major activity (i.e., work, school, household tasks) in any way were 3.9% and 1.3%.[7] Other sources document the higher incidences of prematurity among lower income classes. In one study the prematurity rate in a hospital was 15% among indigent patients and 7.5% among private patients.[8]

In another study, 2,521 premature deliveries were observed in three hospitals over a three year period. The age-specific incidence of prematurity varied according to four socioeconomic classes, with the rate for the highest class under 20 years of age being 8.5 cases per 1,000 live births and the corresponding rate for the lowest class being 21.1.[9]

Infant mortality and fetal mortality rates follow similar patterns. In 1964, the U.S. infant mortality rate for whites was 21.6 per 1,000 live births, while it was 41.1 for nonwhites.[10] The differential for fetal death rate was 13.9 deaths per 1,000 live births for whites and 27.5 for nonwhites, respectively. Since so many Negroes are poor and so many poor are Negro, we are really discussing the same problem under different headings.

Clearly then, the poor in this nation are affected by health problems more severely than are the non-poor. But what impact does disease have on the poor family's income?

It has been demonstrated that, aside from their sources of payment, low income families bear the greatest impact of heavy medical expenses, as measured by the incidence of catastrophic health expenditures among families classified by size and income. In a survey reported in a May, 1970 article[11] of *Public Health Reports*, the official publication of the U.S. Public Health Service, it was indicated that more than 50% of families of 4 earning between $2,000 and $3,000 per annum incurred catastrophic health expenditures—that is, expenditures exceeding 15 percent of annual income less $50 per family member; for families of 4 earning between $5,000 and $6,000, the figure was less than 25 percent. Thus the poor are not only more frequently ill than others, but when sick must withstand a greater financial burden than others, regardless of their source of income. For those individuals unable to bear the burden of medical expenses, many are, in the words of Doctor Alonzo Yerby, "forced to barter their dignity for medical services."[12] The existence of a comprehensive Medicaid program for substantially all the needy will eliminate this intolerable situation.

While Title XIX has resulted in improved medical care for many, it has also had another effect. Because of the existence of Medicaid, municipal and charity hospitals have not expanded to accommodate the health needs of a growing population as they would have in its absence; charitable organizations which previously supported institutions providing free medical and related services have committed their funds elsewhere; and numerous recipients have not made alternative arrangements for medical care in lieu of reliance on Medicaid. There are, however, alternatives that Medicaid programs might employ to insure economic efficiency and program effectiveness. It is the position of the National Legal Program on Health Problems of the Poor that if such alternatives were utilized better methods of delivering personal health services could be obtained insuring both appropriate cost control and consumer accept-

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[6] Dorn, H. F. and Cutler, S. J., *Ibid.*, pp. 116–117.

[7] National Center for Health Statistics, U.S. Dept. H.E.W., Public Health Service, Series 10, No. 45. "Limitations of Activities and Morbidity Due to Chronic Conditions, U.S., July 1965–June 1966." (Government Printing Office, Washington, D.C.) May 1968, p. 9.

[8] Griswold, D. M. and Cavanagh, D., "Prematurity—The Epidemiologic Profile of High-Risk Mother," American J. of Obstetrics and Gynecology 96: 878–882, November 1966.

[9] Donnelly, J. F., et al., "Maternal, Fetal, and Environmental Factors in Prematurity," American J. of Obstetrics and Gynecology 88: 918–928, April 1964.

[10] Hunt, E. P. and Huyck, E. E., "Mortality of White and Nonwhite Infants in Major U.S. Cities," Health, Education and Welfare Indicators, Dept. H.E.W., January 1966, p. 23.

[11] Tucker, M. A., "Effect of Heavy Medical Expenditures on Low Income Families," Public Health Reports 85: 419–425, 1970.

[12] Terby, A. S., "The Disadvantaged and Health Care," Amer. J. of Public Health 56: 101–105, 1966.

ability. Thus, if such alternatives were implemented, it would not be necessary even in the face of spiraling costs in the open medical market place to retreat from the goal of comprehensive health services for substantially all the poor.

Since the latter part of the 1930's several organized practice arrangements have emerged that have demonstrated the capacity to control medical care costs, provide effective services, and render high quality care. What types of organized practice arrangements are they?

1. *Prepaid Group Practice Programs* where medical personnel are located in one site and where there is a use of common resources such as laboratory and x-ray equipment and clerical staff. Group practice projects either provide for directly or arrange for in-patient hospital services as well as rendering ambulatory care.

2. *The Foundation for Medical Care Plans*, best represented by the San Joaquin Foundation in California. Foundations provide direct peer review of costs and quality of services rendered by participating Foundation physicians, the vast majority of whom practice in individual office. Foundations can contract directly with insurance carriers to perform line peer review or can assume part of the carrier function of collecting the prepaid premiums as well as reviewing the price and quality of services rendered by participating physicians. Most Foundations, at the present time, only have administrative control over physician services and not hospital care, extended care facility services, home health services and pharmaceutical services.

3. *The Physicians Association of Clackamas County (PACC)*. Fashioned similarly to the Foundation for Medical Care Plans, the Physicians Association is a non-profit physician sponsored prepaid medical service plan. The physicians assume the underwriting risks rather than other insuring organizations such as commercial health insurance carriers or Blue Cross-Blue Shield. The vast majority of plans offered by PACC provide for inpatient, outpatient, and physician services.

4. *Neighborhood Health Centers* which are group practice operations located in the community providing, in addition to basic medical care, a variety of health related services. In some instances, in-hospital care is also provided either directly or indirectly by contract.

In the above cited organized practice arrangements, five characteristics emerge representing programmatic aspects which can be objectives for Title XIX programs. Several of these characteristics are common to all five programs.

1. Two basic services are offered or provided by private or public contract: ambulatory and hospital care that are administratively integrated. These comprehensive services are provided in such a fashion as to emphasize utilization of ambulatory care and de-emphasize the use of in-hospital activities.

2. Defined population: Individuals are enrolled on a prospective basis by place of residence, employment, relationship to an insurance carrier or by means of a number of other factors.

3. Prepayment: The cost of the health services is arranged over a specified period of time between the consumer or his agent and the provider organization.

4. Integrated management which does the following:

   a. Negotiates what services are to be covered (insurance companies call this "the benefit package") and its cost between the provider and potential enrollees or their agents.

   b. Designs and executes policies of management that either affect or has the potential to affect the activities of the provider. Management policies can vary in content; they can be rather stringent, even to the point of determining what options the physician is allowed in treating various disease states, to rather loose policies which fix charges for medical services. But in all cases there are management policies which are recognized as such and are agreed upon prior to participation by the provider, be that provider an individual or institution.

5. Peer and utilization review: Provides within the framework of the organization peer and utilization review of the cost and quality of services. Peer and utilization review occurs on a regular basis and form part of the back-drop for establishing and executing medical policy.

But what do these characteristics lead to? What, if anything, indicates that these "loose" or "tight" systems are more effective, more efficient, than the ordinary mechanism by which medical care is rendered in this country today.

1. *Utilization of Ambulatory Care in Prepaid Group Practices.* In a recent

study [13] Old Age Assistance (OAA) recipients who used a prepaid group practice program (HIP) were compared to other OAA recipients using the traditional, fee-for-service welfare system. Among other parameters, ambulatory care utilization rates of these two similar groups were studied.

It was found that for the HIP/OAA group, the percentage of non-users decreased from 37% to 30% during the study year. The non-HIP/OAA non-user group remained the same at 45%.

Although 42% of the non-HIP/OAA group received services in their homes and 58% went to the medical office, only 19% of the HIP/OAA group were seen in the home; 81% of their visits were in the physician's office.

Aggregate figures are even more striking. Of the HIP/OAA group, those who didn't receive any services whatsoever, prior to enrollment, averaged at the end of the year 3.1 visits. Those who began the program by using more than 10 visits per annum, were averaging 9.1 visits at the end of the year. The experience of the non-HIP/OAA was quite different. At the end of the study year, non-users were engaging with the physician 1.3 times. Frequent users (more than 10 contracts per year) increased their usage to 14.7 times per annum. Displayed against the experience of the non-HIP/OAA group, the low utilizer OAA recipients in HIP appear to have increased their usage pattern beyond the non-HIP/OAA users and the high utilizer OAA recipients decreased their utilization characteristics, both in terms of their past experience and the experience of the non-HIP group.

2. *Utilization of Ambulatory Care in Neighborhood Health Centers (NHC).* In the most recent experience of the OEO health programs, ambulatory utilization averaged at 4–5 visits per enrolled person per annum. A recent in-depth study of six NHC's confirms this experience.[14] Research [15, 16, 17] dealing with prepaid group practice, of which the NHC can be an example (although method of capitation [annual budget] and characteristics of plan membership [poor and near-poor] are quite different than the privately offered prepaid group practices), found no significant utilization abuse of the services offered in a prepaid group practice setting.

3. *Utilization of Hospital Care in Prepaid Group Practices.* Perhaps more than any other dimension, it is in the area of hospital utilization where differences between the several modes of organization can be noted. Donabedian,[18] in an excellent review of the literature dealing with prepaid group practices, summarized seven studies dealing with hospital utilization.

Donabedian and others have found the utilization of in-patient hospital services decreased by at least thirty per cent in prepaid group practice programs. The tremendous savings of such a reduction are obvious immediately in terms of national expenditures for health care. In a recent report [19] the Kaiser Foundation Health Plan (a prepaid group practice) hospital experience was displayed against the overall California hospital experience.

It would appear that there is less use of hospital beds for Kaiser enrollees than other Californians, even after adjustments for age are made. Again, the sizable reductions appear to be due to lower admission rates.

Item	Kaiser, northern California	Kaiser, southern California	California
1. Hospital days per 1,000	532	520	891
Age adjusted	612		891
2. Average length of stay	6.6	6.0	6.5

[13] Shapiro, S.; Williams, J. J.; Yerby, A. S.: Densen, P. M.; and Rosner, H., "Patterns of Medical Use by the Indigent Aged Under Two Systems of Medical Care", *AJPH* 57: 784–790, 1967.

[14] *Cost Study of Six Selected Neighborhood Health Centers*, O.E.O. unpublished data.

[15] Anderson, O. W. and Sheatsley, P. B., *Comp. Medical Insurance: A Study of Costs, Use and Attitudes Under Two Plans*, Research Series No. 9, (N.Y.: Health Info. Foundation, 1959).

[16] *Family Medical Care Under Three Types of Health Insurance*, School of Public Health and Administrative Medicine, Columbia University, (N.Y.: Foundation on Employee Health, Medical Care and Welfare, Inc., 1962).

[17] *Committee for the Special Research Project in the HIP of Greater N.Y. Health and Medical Care in N.Y.C.* (Cambridge: Harvard University Press, 1957).

[18] Donabedian, A., "An Evaluation of Prepaid Group Practice," *Inquiry*, VI, Sept. 3, 1969.

[19] *Report of the National Advisory Commission on Health Manpower*, Vol. II, November 1967.

But what causes lower admission and/or average length of stay rates that lower so dramatically patient day rates in organized systems of care? Some would argue that it is a lessening of the quality of care, postponement of services to a later point in time. According to the report of the National Advisory Commission on Health Manpower,[20] this did not appear to be the case. The major cause for reduction rests with the marginal reasons for hospitalizing patients—elective surgery, admissions due to upper respiratory infections, and hospitalization for diagnostic procedures that could be handled on an ambulatory basis. Perrott[21] reviewed the experience of the Federal employees who participated in the Federal Employees Health Benefit Program. He discovered that rates for surgical procedures consistently have been lower for those who opt into an organized system than those who do not, even though there appear to be no medical/surgical differences between patients in group practices and non-group practices.

Procedures	Rate of group practice	Rate of nongroup practice
All procedures	0.42	1
Cholecystectomy	.73	1
Female surgery	.51	1
Appendectomy	.50	1
Tonsillectomy and/or adenoidectomy	.23	1

4. *Utilization of Hospital Services in a Neighborhood Health Center.* (*NHC*). Three studies have been done that have looked at this aspect. Two have been published; the third is in press. The first study,[22] published in the *New England Journal of Medicine*, analyzed the effect the operation of a Neighborhood Health Center had on the uses of in-patient hospital services in the city of Boston. Although the study can be criticized on two accounts (that of small sample size and difficulty in tracking patients referred from the NHC to all available hospitals), the *direction* that the organized primary health care program had on hospital utilization is important. Essentially what was found was that the demand for hospital services was reduced dramatically over a three year period. The second study[23] dealt with a defined population using hospitals in only one system—the Kaiser Foundation Medical Care Plan in Portland, Oregon. The under-65 annualized hospital utilization rate for the OEO population was 472 days per 1,000 persons compared with 415 days per 1,000 for the general health plan membership. After an age and sex adjustment for the OEO group was made, the bed-days were approximately 620, which is considerably less than the experience of welfare recipients nationally. One must keep in mind the larger percentage of women in the child bearing ages in the OEO population which probably increased the use of hospital obstetrical services, thus contributing to the 620 bed days. The third study,[24] yet unpublished, is the experience of the Mile Square Health Center in Chicago, Illinois. Through the organized system of primary (ambulatory) care in a NHC in the city of Chicago, the utilization of the hospital was decreased by some 30%.

5. *Summary of the Effect of Organized Practice Arrangements on the Utilization of Ambulatory and Hospital Services.*

a. There appears to be no abuse, either in terms of over or under utilization, of ambulatory services in the organized practice arrangements.

b. There is, however, a redistribution of the demand for ambulatory services: low utilizers tend to increase their demand characteristics; high utilizers tend to decrease their usage.

[20] *Ibid.*, pp. 222–224.

[21] Perrott, G. S. and Chase, J. C., "The Federal Employees Health Benefits Program: Sixth Term Coverage and Utilization," *Group Health and Welfare News*, Special Supplement, (October 1968).

[22] Bellin, S. S.; Geiger, H. J.; and Gibson, C. D., "Impact of Ambulatory-Health-Care Services on the Demand for Hospital Beds," *NEJM*, Vol. 280, No. 15, Apr. 10, 1969, pp. 808–812.

[23] Colombo, T. J.; Saward, E. W.; and Greenlick, M. R., "The Integration of an OEO Health Program into a Prepaid Comprehensive Group Practice Plan", *AJPH*, Vol. 59, No. 4, April 1969. Additional information supplied by Mr. Colombo on May 8, 1970.

[24] Personal conversation with Mr. Gerald Sparer, Chief, Office of Program, Planning, and Evaluation, OEO, Office of Health Affairs.

c. There appears to be a significant reduction in the use of hospital beds in organized systems which in the afore cited studies ranged around 30%.

Costs of providing health care are, of course, a major concern of the National Legal Program, as well as of Government.

1. *Cost of Care in Group Practices.* Donabedian[25] has combined several studies dealing with the costs of providing health services in a variety of systems. It can be gleaned from his study that costs are less across the board for services offered in a prepaid group practice than the fee-for-service, solo practice arrangement. In some instances the service package for organized systems provides more service benefits than the competitor; never are the organized system's service benefits fewer.

2. *Cost of Care in Foundation for Medical Care Systems.* Recently, a study[26] was published that described the costs of rendering services to a Title XIX eligible population through a Foundation for Medical Care Program in California (San Joaquin Foundation). The State of California had arranged prepayment for ambulatory physician services for three categories of Title XIX eligibles. The experience of the Foundation was then compared to the experience of a similar population (of both recipients and providers) and in a county in southern California somewhat identical to San Joaquin but without a Foundation activity.

AVERAGE COSTS PER PATIENT: ALL PHYSICIANS, PARTNERSHIPS, AND GROUPS

	San Joaquin	Ventura County	Percent difference
Total	$31.77	$40.05	26.1
Individual physicians	34.67	38.78	11.9
In area	33.85	37.77	11.6
Out-of-area	46.13	46.88	1.6
Partnership and group	25.99	51.25	97.2
In area	25.54		
Out-of-area	37.65		

The costs for rendering services through the structure of a Foundation was considerably less (26.1% less to be exact) than fee-for-services, solo medical practice. However, if total costs are compared, the story is quite different. Although medical services were less in San Joaquin (ostensibly because of the operation of the Foundation) than in the comparison county, when prescription drugs and services, private hospital care, home health agency services and nursing home activities were included, the cost profiles somewhat changed. For all services, San Joaquin averaged $147.94 per person as opposed to Ventura County which averaged $143.36 per person. This still does not, however, mitigate the apparent savings incurred when ambulatory services are provided within the context of an organized, self-regulated system.

3. *Costs of Services Offered in the Neighborhood Health Center.* One difficulty that constantly besets an economic analysis of the NHC's is how to break down costs. Physician and other medical personnel salaries, cost and amortization of facilities, and medical supplies expenses can all be included in the expenses of delivering medical services. But what of the training programs and other support services such as out-reach and community organizations so important to the Health Center? Where are they placed in the budget? Factoring out just the components that are responsible for delivering medical care and all the support functions that are necessary to that end, it appears that an average medical visit (physician, nurse, facility, equipment, medical supplies, drugs, laboratory, and X-ray) is approximately $20 to $25 per visit.[27] This is not unreasonable when compared to the costs of producing personal health services in the open market place.

It is not the intent of the National Legal Program on Health Problems of the Poor to identify only one way in which health care services can be organized to generate personal health care. We believe, as many do, that there are many alternatives that must be tested and supported. But that there are viable alternatives is a relevant point to make. And the active implementation of those

[25] Donabedian, *op. cit.*

[26] Gartside, F. E. and Procter, D. M., "Medicaid Services in California Under Different Organization Modes, Physician Participation in the San Joaquin Prepayment Project," *School of Public Health, UCLA, Report No. 1*, January 1970.

[27] Personal conversation with Mr. Gerald Sparer, O.E.O.

options will foster an environment in which it will not be necessary to preclude many of the poor from participation in Medicaid or eliminate certain health services because of skyrocketing costs. It is our position that costs can be controlled through organized practice arrangement, and that should be the salient concern of Congress, not the elimination of the primary goal and thrust of Title XIX.

It may be that those who drafted H.R. 17550, noting that the application of Section 1903(e) has been suspended, concluded that it served no purpose and therefore decided to delete it from the Act. As attorneys working in the area of health problems of the poor, we can assure you that the presence of the Section in the Act, together with the present H.E.W. regulations, has served a very important purpose. We therefore urge Congress not to repeal Section 1903(e).

The CHAIRMAN. Thank you very much.

The next witness will be Mrs. Elizabeth Boggs, chairman of the Governmental Affairs Committee, National Association for Retarded Children.

Is Mrs. Boggs here?

(No response.)

The CHAIRMAN. Then we will call the next witness, Mr. Harry Williams, chairman of the American Insurance Association and chairman of the board and president of the Hartford Insurance Group.

STATEMENT OF HARRY V. WILLIAMS, CHAIRMAN, AMERICAN INSURANCE ASSOCIATION; ACCOMPANIED BY DeROY THOMAS, STAFF, HARTFORD INSURANCE GROUP; AND ANDREW KALMYKOW, COUNSEL, AMERICAN INSURANCE ASSOCIATION

Mr. WILLIAMS. Mr. Chairman, my name is Harry V. Williams. I am chairman of the board and president of the Hartford Insurance Group, and chairman of the American Insurance Association, on behalf of which I have the privilege of appearing before you today.

I have with me two associates, Mr. DeRoy Thomas of the Hartford staff, and Mr. Andrew Kalmykow of the American Insurance Association staff.

The American Insurance Association is a national nonprofit organization composed of 106 stock insurance companies writing all lines of casualty and property insurance, including workmen's compensation throughout the United States.

It is my purpose to deal with only one important aspect of H.R. 17550. That is, the adverse impact it will have upon our workmen's compensation system and upon injured employees and their dependents who are protected by that system as well as their employers and insurance carriers.

Our member companies are vitally concerned with the satisfactory operation of the compensation system. They feel it is important that social security and workmen's compensation be coordinated so that the proper development of each system be not impeded. They and many others are firmly convinced that the overlap of social security and workmen's compensation must be kept to a minimum if irreparable damage to the latter is to be avoided.

We believe that a substantial advance towards this objective was made when, as a result of the recommendations of this committee in 1965, the extent of the overlap was limited—section 224, Social Security Act, section 424, United States Code Annotated. Under this provision, social security disability benefits when added to workmen's

compensation may not exceed 80 percent of an employee's average current earnings before disability. This placed a limitation on the undesirable duplication of such benefits which had existed since 1958.

This committee then stated:

> The committee has taken note of the concern that has been expressed by many witnesses in the hearings about the payment of disability benefits concurrently with benefits payable under State workmen's compensation programs . . . Although there is some dispute as to the number of workers who receive benefits under these two programs and whether these payments are excessive, the committee believes that it is desirable as a matter of sound principle to prevent the payment of excessive combined benefits. (Social security amendments if 1965, report of the Committee of Finance, U.S. Senate to accompany H.R. 6675, 89th Cong., First sess., calendar No. 389, Rept. 404, part I, p. 100.)

The current bill, section 114, would destroy this limitation and permit combined benefits up to 100 percent of average current earnings.

Since income and social security taxes would not have to be paid, and other expenses of employment would not have to be incurred, an employee receiving these combined benefits would have a higher net income than he did when working. This would remove any incentive for rehabilitation.

Rehabilitation is a socially beneficial keystone in both workmen's compensation and OASDI, as well as in all privately funded employee welfare programs. Motivation is extremely important for successful rehabilitation and economic incentives are significant in creating such motivation. Appended to this statement are several typical examples of cases where rehabilitation was impeded by lack of financial incentives.

More importantly, however, adoption of this proposal would result in a freeze of workmen's compensation benefits at current levels. Workmen's compensation is a medical care and partial wage loss replacement program. If social security disability benefits supplement workmen's compensation up to 100 percent of wages, the State's incentive to increase compensation benefits is eliminated.

Benefits would tend to remain static not only with respect to the type of injuries for which social security disability benefits are presently being made, but also to other disabilities to which the Social Security Act is likely to be extended either through legislation or broadened interpretation. This will adversely affect the many permanently injured employees who are not entitled to social security benefits but must rely on workmen's compensation alone.

Even the present 80 percent provision has had a chilling effect on compensation benefit increases. For example, prior to the enactment of social security disability benefit legislation in 1956, maximum weekly compensation for permanent total disability was usually the same as that payable under the State act for temporary total disability. Since then, 11 States have provided lower benefits for permanent total disability. That is the type of disability where payment of both social security disability benefits and workmen's compensation is most likely to occur. Yet not all injured employees are entitled to benefits from both sources.

These States and the dates when the changes in benefits were enacted are as follows:

Alaska, 1959; California, 1959; Illinois, 1965; Iowa, 1959; Missouri, 1959; Montana, 1969; New York, 1968; Ohio, 1967; Oklahoma, 1957; Oregon, 1959; Rhode Island, 1959 but difference restored 1959.

The adverse effect on employees is illustrated by the situation in New York. In that State this year temporary disability benefits were increased to $95 a week, but persons suffering permanent disability, either total or partial, had their increase limited to $80 a week. Most of these individuals are not entitled to social security disability benefits. They lost $15 a week as a result of even the current supplementary provisions of the Social Security Act.

According to figures of the Social Security Administration as of the end of April 1970, there was 19,481 disabled workers affected by the workmen's compensation offset provision. In New York alone for the year 1966, the latest available data, 49,968 employees suffered permanent partial disability and 173 suffered permanent total disability. Compensated cases closed 1966, New York Workmen's Compensation Board, Bulletin 21, research and statistics table 3, page 22.

Thus, in that State alone, far more employees have already been penalized by the existing provision of the Social Security Act than would be benefited countrywide by the proposed supplementary benefit. A relatively small benefit for the few would have serious adverse financial effect on the many.

It is most unlikely that any increase for permanent disability would have been enacted in New York this year if combined social security and workmen's compensation, as proposed in the bill, could have equaled 100 percent of wage. Maximum weekly compensation benefits for temporary disability have increased more than the 31 percent countrywide since 1965 when the present provision coordinating social security disability benefits and workmen's compensation was enacted.

This exceeds the increase in the cost of living for that period. The countrywide maximum average for temporary disability is now more than $70.50 a week and amounts to more than 68 percent of take-home pay. This trend might be reversed if the proposed amendment is adopted. Tables indicating compensation benefits for both temporary disability and permanent disability in relation to wages and take-home pay are attached.

It is to be noted that in all compensation cases, medical payments are provided, usually unlimited in time and amount. Thus, the injured employee does not have to bear the cost of medical care for his injuries. He is in a much better financial position than other disabled individuals not covered by workmen's compensation.

The disabled employee and his family who is entitled to workmen's compensation as well as social security disability benefits receives far more than those entitled only to social security benefits. Thus, one cannot properly regard the offset provision as a reduction in social security benefits, as some have contended, but rather social security should be regarded as a supplement to workmen's compensation. Under existing provision allowing combined benefits up to 80 percent of wages, they are already receiving far more than other social security disability beneficiaries.

Preferably, of course, social security should not duplicate or supplement workmen's compensation. When social security disability benefits were first adopted in 1956, there was no duplication. Workmen's compensation was deducted from the disability benefit. This provision was unexpectedly repealed in 1958, without adequate opportunity to be

heard and apparently without realization of the adverse effects of the change.

Duplicate benefits considerably in excess of wages were frequently made. Some States tried to reduce compensation benefits or provided lower benefits for long-term injuries where duplication was likely. These adverse effects on compensation benefit levels and on rehabilitation became evident and the Congress, upon the recommendation of this committee, we believe wisely, in 1965 enacted the existing provision. This in itself was a compromise for many contended that the full offset provision which was originally in the law should be reenacted. The current 80-percent provision was adopted as a compromise and is roughly equivalent to the economic loss in most cases.

Section 114 of H.R. 17550 would virtually repeal this provision and cause a return to the unsatisfactory conditions which existed before 1965.

We all share great sympathy for the plight of a disabled person, but we believe that the advocates of change in the present provisions coordinating workmen's compensation and social security do not realize the adverse effects of their proposal on injured workmen. We are pleased to note that the Social Security Administration, upon questioning by a member of this committee at an earlier hearing, expressed opposition to enactment of section 114. We respectfully urge you to support that position.

(Appendices to the above statement follow. Hearing continues on p. 912.)

APPENDIX A

State	Average weekly wage [1]	Taxes (Federal income and FICA) [2]	Take-home pay	Maximum workmen's compensation temporary total disability benefit	Percentage of take-home pay
Alabama	$98.29	$10.52	$87.77	$50.00	57
Alaska	214.24	34.98	179.26	[3] 127.00	71
Arizona	130.29	17.05	113.24	152.50	135
Arkansas	94.34	9.53	84.81	49.00	58
California	136.36	18.15	118.21	87.50	74
Colorado	116.40	14.19	102.21	59.50	58
Connecticut	128.26	16.26	112.00	80.00	71
Delaware	112.11	13.18	98.93	75.00	76
District of Columbia	119.69	14.35	105.34	70.00	66
Florida	106.84	12.23	94.61	56.00	59
Georgia	102.85	11.24	91.61	50.00	55
Hawaii	136.55	18.15	118.40	112.50	95
Idaho	121.63	15.14	106.49	99.00	93
Illinois	129.02	16.29	112.73	91.00	81
Indiana	117.34	14.23	103.11	57.00	55
Iowa	114.22	13.28	100.94	61.00	60
Kansas	115.15	14.13	101.02	56.00	55
Kentucky	108.35	12.30	96.05	52.00	54
Louisiana	116.20	14.18	102.02	49.00	48
Maine	101.99	11.20	90.79	73.00	80
Maryland	116.28	14.18	102.10	[4] 81.50	80
Massachusetts	123.34	15.22	108.12	88.00	81
Michigan	137.55	18.20	119.35	104.00	87
Minnesota	118.51	14.29	104.22	70.00	67
Mississippi	93.23	9.08	84.15	40.00	48
Missouri	115.47	14.14	101.33	63.50	63
Montana	129.78	16.33	113.45	[5] 65.00	57
Nebraska	111.27	13.14	98.13	55.00	56
Nevada [6]	131.65	17.12	114.53	79.96	70
New Hampshire	109.80	12.37	97.43	67.00	69
New Jersey	117.12	14.22	102.90	91.00	88
New Mexico	116.79	14.21	102.58	48.00	47
New York	120.92	15.10	105.82	95.00	90
North Carolina	99.05	10.55	88.50	50.00	56
North Dakota [6]	106.43	12.21	94.22	94.00	100
Ohio [6]	137.40	18.20	119.20	63.00	53
Oklahoma	106.18	12.20	93.98	49.00	52
Oregon	131.62	17.12	114.50	80.00	70
Pennsylvania	120.51	15.08	105.43	60.00	57
Rhode Island	114.80	13.31	101.49	82.00	81
South Carolina	97.13	10.06	87.07	50.00	57
South Dakota	105.52	12.16	93.36	50.00	54
Tennessee	100.61	11.13	89.48	47.00	53
Texas	113.34	13.24	100.10	49.00	49
Utah	113.47	13.25	100.22	65.00	65
Vermont	111.38	13.15	98.23	61.00	62
Virginia	104.62	11.32	93.30	62.00	66
Washington [6]	135.50	18.10	117.40	81.23	69
West Virginia [6]	131.00	17.09	113.91	65.50	58
Wisconsin	120.06	15.06	105.00	79.00	75
Wyoming [6]	105.70	12.17	93.53	63.46	68
Average	118.10	14.27	103.83	70.75	68

[1] National Council on Compensation Insurance, Dec. 31, 1969, wage data.
[2] 4 exemptions.
[3] As of Sept. 1, 1970.
[4] First 42 days at $55, then $81.50 for duration.
[5] During first 26 weeks, then $60.
[6] U.S. Department of Labor, Bureau of Labor Statistics, August 1970.

APPENDIX B

State	Average weekly wage [1]	Taxes, Federal income and FICA [2]	Take-home pay	Maximum workmen's compensation permanent total disability benefit	Percentage of take-home pay
Alabama	$98.29	$10.52	$87.77	$50.00	57
Alaska	214.24	34.98	179.26	[3] 82.55	46
Arizona	130.29	17.05	113.24	152.50	135
Arkansas	94.34	9.53	84.81	49.00	58
California	136.36	18.15	118.21	52.50	44
Colorado	116.40	14.19	102.21	59.50	58
Connecticut	128.26	16.26	112.00	80.00	71
Delaware	112.11	13.18	98.93	75.00	76
District of Columbia	119.69	14.35	105.34	70.00	66
Florida	106.84	12.23	94.61	56.00	59
Georgia	102.85	11.24	91.61	50.00	55
Hawaii	136.55	18.15	118.40	112.50	95
Idaho	121.63	15.14	106.49	99.00	93
Illinois	129.02	16.29	112.73	71.00	60
Indiana	117.34	14.23	103.11	57.00	55
Iowa	114.22	13.28	100.94	56.00	55
Kansas	115.15	14.13	101.02	56.00	55
Kentucky	108.35	12.30	96.05	52.00	54
Louisiana	116.20	14.18	102.02	49.00	48
Maine	101.99	11.20	90.79	73.00	80
Maryland	116.28	14.18	102.10	85.00	83
Massachusetts	123.34	15.22	108.12	88.00	81
Michigan	137.55	18.20	119.35	104.00	87
Minnesota	118.51	14.29	104.22	70.00	67
Mississippi	93.23	9.08	84.15	40.00	48
Missouri	115.47	14.14	101.33	58.00	57
Montana	129.78	16.33	113.45	[4] 65.00	57
Nebraska	111.27	13.14	98.13	55.00	56
Nevada [5]	131.65	17.12	114.53	66.46	58
New Hampshire	109.80	12.37	97.43	67.00	69
New Jersey	117.12	14.22	102.90	91.00	88
New Mexico	116.79	14.21	102.58	48.00	47
New York	120.92	15.10	105.82	80.00	76
North Carolina	99.05	10.55	88.50	50.00	56
North Dakota [5]	106.43	12.21	94.22	94.00	100
Ohio [5]	137.40	18.20	119.20	56.00	53
Oklahoma	106.18	12.20	93.98	43.00	46
Oregon	131.62	17.12	114.50	62.50	55
Pennsylvania	120.51	15.08	105.43	60.00	57
Rhode Island	114.80	13.31	101.49	82.00	81
South Carolina	97.13	10.06	87.07	50.00	57
South Dakota	105.52	12.16	93.36	50.00	54
Tennessee	100.61	11.13	89.48	47.00	53
Texas	113.34	13.24	100.10	49.00	49
Utah	113.47	13.25	100.22	65.00	65
Vermont	111.38	13.15	98.23	61.00	62
Virginia	104.62	11.32	93.30	62.00	66
Washington [5]	135.50	18.10	117.40	81.23	69
West Virginia [5]	131.00	17.09	113.91	65.50	58
Wisconsin	120.06	15.06	105.00	79.00	75
Wyoming [5]	105.70	12.17	93.53	63.46	69
Average	118.10	14.27	103.83	67.46	65

[1] National Council on Compensation Insurance, Dec. 31, 1969, wage data.
[2] 4 exemptions.
[3] As of Sept. 1, 1970.
[4] During first 26 weeks, then $60.
[5] U.S. Department of Labor, Bureau of Labor Statistics, Aug. 1970.

APPENDIX C.—WORKMEN'S COMPENSATION, BENEFITS FOR TOTAL DISABILITY

State	Maximum percent		Maximum weekly		Maximum period		Maximum total	
	Temporary	Permanent	Temporary	Permanent	Temporary	Permanent	Temporary	Permanent
Alabama	65	65	$50.00	$50.00	300 weeks	550 weeks	$15,000	$20,000
Alaska	65	65	127.00	82.55	During disability	Life	17,000	(1)
Arizona	65	65	[2 3] 150.00	[2] 150.00	433 weeks [2]	do.[2]	(2)	(2)
Arkansas	65	65	49.00	49.00	450 weeks		19,500	
California	65	[4] 65	87.50	52.50	240 weeks	do.[4]		
Colorado	66⅔	66⅔	59.50	59.50	Disability	Disability	18,624	18,624
Connecticut	66⅔	66⅔	[5] 80.00	[5] 80.00	do	do		
Delaware	66⅔	66⅔	75.00	75.00	do	do		
District of Columbia	66⅔	66⅔	70.00	70.00	do	do	24,000	(1)
Florida	60	60	$56.00	56.00	350 weeks	do	19,600	(1)
Georgia	60	60	50.00	50.00	400 weeks	400 weeks	18,000	18,000
Hawaii	66⅔	66⅔	112.50	112.50	Disability	Disability	35,100	(1 6)
Idaho	60	60	99.00	99.00	do [7]	do [7]	(1 7)	(1 7)
Illinois	80	80	91.00	71.00	do	do	25,200	[8] 25,200
Indiana	60	60	57.00	57.00	500 weeks	500 weeks [9]	25,000	25,000
Iowa	66⅔	66⅔	[10] 61.00	[10] 56.00	300 weeks	do		
Kansas	60	60	56.00	56.00	415 weeks	415 weeks	23,240	23,240
Kentucky	(11 12)	(11 12)	[12] 52.00	[12] 52.00	425 weeks	425 weeks	19,975	19,975
Louisiana	65	65	49.00	49.00	300 weeks	500 weeks		
Maine	66⅔	66⅔	[13] 73.00	[13] 73.00				
Maryland	66⅔	66⅔	[14 15] 81.50	85.00	4 years	Disability	11,440	45,000
Massachusetts	66⅔	66⅔	[16] 70.00	[16] 70.00	Disability	do	16,000	(1)
Michigan	66⅔	66⅔	[17] 104.00	[17] 104.00	do	800 weeks		
Minnesota	66⅔	66⅔	70.00	70.00	350 weeks [18]	Disability	24,500	(1)
Mississippi	66⅔	66⅔	40.00	40.00	450 weeks [19]	450 weeks [19]	15,000	[19] 15,000
Missouri	66⅔	66⅔	63.50	58.00	400 weeks	Life [20]	25,400	
Montana	66⅔	66⅔	[21] 65.00	[21] 65.00	300 weeks	500 weeks (time may be extended).	18,000	30,000
Nebraska	66⅔	66⅔	55.00	55.00	do	Life [22]	16,500	
Nevada	(23)	(24)	79.96	66.46	100 months	Disability	[25] 29,250	
New Hampshire	66⅔	66⅔	[26] 67.00	[26] 67.00	Disability	do		
New Jersey	(27)	(27)	[27] 91.00	[27] 91.00	300 weeks [27]	450 weeks [27]		
New Mexico	60	60	[28] 48.00	[28] 48.00	500 weeks	500 weeks	24,000	24,000
New York	66⅔	66⅔	95.00	80.00	Disability	Life		(29)
North Carolina	60	60	50.00	50.00	400 weeks	400 weeks [30]	18,000	[30] 18,000
North Dakota	[31] 55	[31] 55	[31] 94.00	[31] 94.00	Disability	Disability		
Ohio	66⅔	66⅔	[33] 63.00	[34] 56.00	do	Life	10,750	(32)
Oklahoma	66⅔	66⅔	49.00	43.00	300 weeks	500 weeks	14,700	22,500
Oregon	90	90	80.00	62.50	Disability	Disability	(35)	(35)
Pennsylvania	66⅔	66⅔	60.00	60.00	do	do		
Puerto Rico			45.00	28.85	312 weeks	do		
Rhode Island	[36] 66⅔	[36] 66⅔	[37] 82.00	82.00	Disability	do	32,500	[38] 32,500
South Carolina	66⅔	66⅔	50.00	50.00	do	500 weeks	12,500	12,500

APPENDIX C.—WORKMEN'S COMPENSATION, BENEFITS FOR TOTAL DISABILITY—Continued

State	Maximum percent		Maximum weekly		Maximum period		Maximum total	
	Temporary	Permanent	Temporary	Permanent	Temporary	Permanent	Temporary	Permanent
South Dakota		55	50.00	50.00		Life[39]		78,000
Tennessee	65	65	47.00	47.00	300 weeks	550 weeks[39]		18,800
Texas	60	60	49.00	49.00	401 weeks	401 weeks		
Utah	60	60	65.00	65.00		Life[40]	20,280	20,280
Vermont	[41] 66⅔	[41] 66⅔	[41] 61.00	[41] 61.00	330 weeks	330 weeks		20,130
Virginia	60	60	62.00	62.00	500 weeks	500 weeks	$31,200	31,200
Washington			81.23	81.23	Disability	Disability		
West Virginia	[42] 66⅔	[42] 66⅔	65.50	65.50	208 weeks	Life	11,232	
Wisconsin	70	70	79.00	79.00	Disability	Disability[43]		
Wyoming	66⅔		63.46	63.46				[44] 17,500
Longshoremen's Act	66⅔	66⅔	[45] 70.00	[45] 70.00	Disability	Disability	24,000	(1)
Average			70.16	66.74				

[1] No limit.
[2] Different for O.D.
[3] Plus $2.50 per each dependent.
[4] Reduced to 40 percent after 240 weeks.
[5] 60 percent of average industrial wage.
[6] Plus $5,000 maximum for rehabilitation.
[7] Benefits reduced after 400 weeks; $51 + $8 per each child, maximum C.
[8] Thereafter pension 15 percent of benefits paid.
[9] Additional payments from 2d injury fund.
[10] As of July 1, 1970—based on 50 percent of State average weekly wage.
[11] 55 percent of 85 percent.
[12] Of State average weekly wage.
[13] As of June 1, 1970. Added benefits during rehabilitation.
[14] $55 for first 42 days.
[15] As of Jan. 1, 1970.
[16] Plus $6 for each dependent not to exceed wage (3 dependents).
[17] $75 plus $6 for each dependent up to 5, maximum $104. May be extended.
[18] Maximum of 104 weeks compensation during retraining.
[19] Whichever one is less plus $10 weekly rehabilitation 52 weeks.
[20] 50 percent after 300 weeks plus $10 rehabilitation 40 weeks.
[21] Includes allowance for 5 dependents, plus $30 weekly maximum during rehabilitation maximum payable for 1st 26 weeks.
[22] After 300 weeks maximum weekly of $41 or 45 percent; compensation plus maintenance payable during rehabilitation.
[23] 90 percent of $385 per month.
[24] 90 percent of $320 per month.
[25] Plus $50 monthly for attendant, if needed. Maximum weekly 65 percent of State average weekly wage, plus 15 percent per dependent, maximum 90 percent amount specified.
[26] Maintenance during rehabilitation.
[27] As per wage schedule. Period extended during rehabilitation. Annually ⅔ of average industrial wage after Jan. 1, 1970.
[28] Extra compensation during rehabilitation not to exceed $1,000.
[29] Extra compensation during rehabilitation $30 weekly.
[30] For life in case of brain or spinal injury.
[31] 55 percent of State average weekly wage on July 1 annually, plus $5 each child; maximum not to exceed net wage after taxes. 1970 average wage equals $106.
[32] Plus $25 weekly for 72 weeks rehabilitation.
[33] During first 12 weeks.
[34] Plus $40.25 for 52 weeks of scheduled injury rehabilitation.
[35] Added benefits during rehabilitation.
[36] Not to exceed 60 percent of average State wage or $70, plus $6 for each dependent.
[37] 2 children.
[38] After 300 weeks, $15 maximum weekly.
[39] Reduced to $15 after 400 weeks.
[40] Includes $3.60 for each dependent child, maximum of 4; after 260 weeks from special fund. Plus $890 during rehabilitation.
[41] Includes $3.50 for each dependent child. Maximum not to exceed 50 percent of average annual State wage, July 1, 1970.
[42] Maximum not to exceed 50 percent of State average weekly wage. Plus $1,200 during rehabilitation.
[43] Plus expenses during 40 weeks rehabilitation.
[44] Plus $7.50 for each child. Maximum $10,000.
[45] Plus $25 weekly during rehabilitation.

APPENDIX D

Typical Cases

(Rehabilitation Impeded by Lack of Financial Incentive During Period of Full Duplication of Workmen's Compensation and Social Security Disability Benefits Prior to 1965)

CASE ONE

This case resulted from an injury to a 36 year old claimant in July 1962. This claimant suffered multiple fractures but eventually became ambulatory but had enough residual disability to preclude him from preforming his former occupation of carpentry. The case was reported to us in May of 1966 and again was earmarked for a permanent and total disability situation with a lifetime exposure. We had a very difficult time in even communicating with this claimant. He was receiving $70 per week in compensation indemnity, $254 per month in Social Security Disability Benefits and $20 per month in V.A. Disability providing a tax free income of $577. His pre-accident gross was $474 per month and he had car expenses in commuting an hour to work. This man and his family lived in a rural area, had two cars, a color television set, a modest but nicely furnished home, and a swimming pool in the backyard. I know that the color television set, the swimming pool, and one of the cars were purchased following his compensable accident. While interviewing this man one day and attempting to interest him in a rehabilitation program, I explained that his compensation benefits and Social Security Disability Benefits would not keep pace with inflation and his cost of living. This was at a time when President Johnson was recommending a 12% increase in Social Security Disability Benefits. This claimant has a below average I.Q., had completed eight years of schooling but we later determined by testing that his competency level was 4.5 years of education. At the interview the claimant said to me, "Mr. ———, did your employer give you a 12% raise this year?"

To further show the role that the disability benefits were playing in this case, I will add that we were able, finally, to enter the claimant into a rehabilitation program and he was retrained and is now working for an income much greater than before he was originally hurt. In other words, even with the limited education, this man was capable and had adequate mechanical ability to perform on the open labor market. The pivotal point was when we determined that over the previous four years this man had expended $5,000 for his wife's health care and we were able to explain that if he were employed he would have a health insurance program which would pay the majority of such expenses. It was this argument alone that persuaded this man to enter a rehabilitation program. Otherwise, he was quite content to sit around the house, the local firehouse, or the local tavern and pass the time of day.

CASE TWO

A laborer, age 36, in May 1961, while climbing out of a tank, was struck on the lower back. After following a course of conservative treatment, he was operated upon in January 1962, for removal of a ruptured L-4-5 intervertebral disc and a spinal fusion was performed. Medical opinion indicated a good recovery, the spinal fusion solid, but the employee continued to complain of pain.

In cooperation with the Florida Industrial Commission, this employee was referred to the Curtis Hixon Rehabilitation Center of the Tampa General Hospital for vocational evaluation in April 1963. He exhibited a negativistic attitude throughout the entire 3 weeks evaluation and the Center's report concluded, "It seems unlikely that ——— will be interested in finding employment as long as he is receiving the sizable income which he has monthly. He does not appear motivated for future employment and constantly emphasizes the amount of discomfort he is in."

The employee's wages at the time of the accident were $80.00 per week and since the accident, he has been receiving Florida compensation benefits plus Social Security benefits which total $100.66 tax free.

CASE THREE

"On December 27, 1960, the claimant, then 55 years of age, suffered an industrial injury which resulted in a partial amputation of his foot. He was fitted with a prosthetic appliance. In December 1962, the claimant was found to be using

the prosthesis but a few hours a day and was still carried by the insurer as totally disabled.

At the instigation of the rehabilitation specialist of the insurer, the claimant's attending surgeon was interviewed in respect of the desirability of this man's submitting to a comple rehabilitation evaluation with the objective of his submitting to rehabilitation service. The attending surgeon concurred in the view that such an evaluation was desirable. Claimant, now age 58, expressed no desire to submit to rehabilitation. In the rehabilitation interview be pointed out that if he went back to work his social security at 62 would be based on earnings between now and then, which would probably be small because of an anticipated residual partial disability even after rehabilitation, and his social security benefit would accordingly be much less than his present $118 per month. The claimant's words in respect of submitting to rehabilitation service were, "I would be cutting my own throat even if I could be rehabilitated at all."

This man's average weekly wage at the time of injury was $85. Today his combined workmen's compensation benefits and social security benefits amount to $72.23 per week tax free. The jurisdiction is Massachusetts."

CASE FOUR

A 58 year old laborer, earning $72 per week, incurred a fracture of the left lower leg at the knee when he fell from a truck in July 1956. He was totally disabled for several years, but has now recovered sufficiently to return to selected employment. Efforts at physical and vocational rehabilitation were frustrated by the employee's lack of initiative and antagonistic attitude. It was disclosed that he applied for Social Security benefits. The case was referred to the Massachusetts Rehabilitation Commission, but they felt that with poor motivation, lack of education, and no incentive, he would not adapt readily to further rehabilitation. The combination of Compensation and Social Security benefits will undoubtedly excessd his former salary, making return to employment for economic reasons unnecessary.

The CHAIRMAN. I think it would help strengthen your position, if indeed it needs any strengthening, if I would ask that there be included right after your statement the last of page 77 and the earlier part of page 78, where this matter was discussed between Senator Talmadge and Mr. Ball, where the administration supports your position with regard to this amendment. I have instructed our staff to be sure that we are fully apprised of his problem before we pass on this in executive session.

There is apparently a great deal in what you have to say, and we will work it out in executive session.

Mr. WILLIAMS. Thank you very much.

Are there any other questions? If not, let me thank you.

The CHAIRMAN. I do not think it requires any more questions. I think you made a good case. If I were you I would quit while I am winning.

Mr. WILLIAMS. That is always a good thing.

The CHAIRMAN. Senator Anderson, do you have any questions?

Mr. WILLIAMS. I am sorry, sir.

Senator ANDERSON. Does the American Insurance Association cover all compensations carriers?

Mr. WILLIAMS. No. The American Insurance Association is an association of 106 stock insurance carriers. However, I believe that there have been positions expressed, am I not right, for other members of the mutuals and other stock insurance carriers.

Mr. KALMYKOW. I believe they are scheduled, Mr. Chairman, to appear somewhat later in the week, and I believe they will more or less, on this particular part, express a similar viewpoint.

Mr. WILLIAMS. We do represent many of the largest writers of compensation in the United States, sir.

Senator ANDERSON. And if you do not, some others will cover it?

Mr. WILLIAMS. They will take care of their own position in due course, Senator.

Incidentally, I am also vice president of the HIA, which is the Health Insurance Association, and I believe they will support this position in the latter part of the week.

The CHAIRMAN. Thank you very much, gentlemen.

Now, next is Mrs. Elizabeth Boggs. Is she here?

(No response.)

The CHAIRMAN. If not, I will next call Mr. Armand Stalnaker, president of the General American Life Insurance Co., St. Louis, on behalf of the American Life Convention, and Life Insurance Association of America.

STATEMENT OF ARMAND C. STALNAKER, PRESIDENT, GENERAL AMERICAN LIFE INSURANCE CO., OF ST. LOUIS

Mr. STALNAKER. For the record, my name is Armand C. Stalnaker. I am president of the General American Life Insurance Co., of St. Louis.

I appear today on behalf of the American Life Convention, the Life Insurance Association of America, and the Life Insurers Conference. These three associations have an aggregate membership of 407 life insurance companies accounting for 93 percent of the life insurance in force in the United States. These companies also hold 99 percent of the reserves of insured pension plans in the United States. We appreciate this opportunity to express our views on H.R. 17550.

Since the social security system first began, Congress has not seemed to intend that it be the only means for providing retirement security for Americans. Rather, social security has been designed to provide individuals with basic income protection in their retirement.

It is important that the social security system not be structured or expanded so as to impede the ability of individuals and their employers to provide additional retirement income through private savings media.

For the economy as a whole, maintenance of a strong private retirement income system is also important as a source of investment capital.

The social security system, quite properly, does not generate capital but simply redistributes most of the tax revenue received.

Within this frame of reference, I would like now to discuss three of the major provisions of H.R. 17550. My formal statement covers these provisions in more detail and also comments on certain other provisions of the bill.

H.R. 17550 would increase benefits by 5-percent across the board in January 1971. We recognize that this increase will reasonably represent the increase in the cost of living since January 1970, the effective date of the 15-percent increase enacted last year.

It should be noted, however, that the 15-percent increase came at the time when the Consumer Price Index had risen only 10.8 percent over its level in February 1968, the date of the prior increase.

We would further note that the combined cost of the 15-percent and the 5-percent increases, when added to the cost of the other proposed benefit liberalizations, as well as increased medicare costs, will exert serious pressures on the financing mechanism. Most certainly, the increase should not exceed 5 percent at this time.

We do not favor the automatic adjustment provisions applicable to benefit levels, the taxable wage base, and the retirement test. We believe that the extent and timing of changes in either benefits or taxes are of such importance that prior review by Congress is necessary in order to tailor the changes to fit the economic situation prevailing at that time.

We are confident that Congress will, as part of its periodic reviews of the social security system, continue to make necessary adjustments to reflect cost-of-living increases.

Also, we believe the automatic adjustment provisions would be interpreted by many as an explicit acknowledgment of the inevitability of continued inflation.

H.R. 17550 would increase the earnings base, that is, the base on which the social security benefits and taxes are computed, from the present level of $7,800 to a level of $9,000 effective January 1, 1971. We believe this increase would be premature.

We believe the average earnings of regularly employed male workers represent an appropriate dividing line between the area in which the Government should have responsibility to provide basic retirement benefits, and the area in which the individual and his employer should have responsibility to provide retirement security through private media.

Under our estimates, the average earnings of regularly employed male workers will not reach the $9,000 wage base contained in H.R. 17550 until 1974 or 1975. An increase to $9,000 on January 1, 1971, would bring the earnings base to a level substantially in excess of the estimated average earnings at that time.

Moreover, using an increase in the earnings base as a mechanism for financing across-the-board benefit increases is an inefficient process. This is so because part of the additional revenue which is raised will be drained off into providing benefits on the newly included higher earnings for those with above-average incomes.

Until the level of average earnings justifies an increase in the taxable base, increases in social security benefits should be financed through any favorable actuarial balance in the present program, and beyond that the social security tax rates should be adjusted to provide the necessary funds.

Adherence to these principles will insure that the social security system remains self-supporting while at the same time financing its benefit increases efficiently and retaining its designed relationship to private retirement media.

Again, let me express appreciation for this opportunity to present the views of our three associations.

Thank you.

(The prepared statement of Mr. Stalnaker follows. Hearing continues on page 918.)

STATEMENT OF THE AMERICAN LIFE CONVENTION, LIFE INSURANCE ASSOCIATION OF AMERICA, AND LIFE INSURERS CONFERENCE, PRESENTED BY ARMAND C. STALNAKER

My name is Armand C. Stalnaker. I am President of the General American Life Insurance Company of St. Louis.

I appear today on behalf of the American Life Convention, the Life Insurance Association of America and the Life Insurers Conference. These three associations have an aggregate membership of 407 life insurance companies accounting for 93 percent of the life insurance in force in the United States. These companies also hold 99 percent of the reserves of insured pension plans in the United States. We appreciate this opportunity to express our views on H.R. 17550.

SOCIAL SECURITY'S ROLE

It has been the clear policy of Congress since the inception of the Social Security system that it is not intended to be the sole means for providing retirement security for American workers and their families. Rather, Social Security has properly been designed to be a vehicle for providing individuals with basic economic protection in their retirement. Individuals have been able to obtain retirement income above this level by using various private savings media, including insurance company products.

Private plans offer flexible arrangements which can be designed to fit an individual's particular needs. The necessity for providing nearly universal coverage does not permit the Social Security system to offer this flexibility. Another difference between Social Security and the private system is that the latter offers products with benefits fully geared to the level of contributions. Thus, an individual in the private market is able to determine for himself—on the basis of his own spending priorities—the level of retirement income he desires and to provide accordingly. Individual choice of this nature is an integral part of a free economy. Consistent with this framework, it is important that the Social Security system not be structured or expanded so as to impede the ability of individuals to provide income for their retirement through private savings media over the Social Security floor of protection.

Maintenance of a strong private retirement income system is also important for the economy as a whole. It is generally agreed that, if our economy and productivity are to grow in the years ahead, there must be an increasing supply of new investment capital. Savings through life insurance and pension funds and other private savings media make a major contribution to this supply of capital. If Social Security benefits are expanded at the expense of private pension funds and savings, there will be a reduction in the generation of capital, since, in contrast to private savings, the Social Security system, quite properly, does not generate capital but redistributes each year most of the tax revenue received.

We believe Congress should review from time to time not only the benefit levels under the Social Security system but also the other aspects of the system to determine whether it is properly carrying out its role. Proposals to increase Social Security benefits must be considered, however, not only in terms of broad social need but also in terms of their cost and the proper relationship between public and private programs. While necessary changes and improvements should be made, we cannot stress enough the fact that undue expansion of the Social Security system would have a far-reaching impact on voluntary private mechanisms and, in turn, on our economy as a whole.

Within this frame of reference, I would now like to discuss the major provisions of H.R. 17550 and certain other proposals which have been made to amend the Social Security system.

ACROSS-THE-BOARD INCREASE

H.R. 17550 would increase benefits by 5 percent across the board in January 1971. We recognize that this increase will reasonably represent the increase in the cost of living since January 1970, the effective date of the 15 percent increase enacted last year. We would note, however, that the 15 percent increase came at a time when the consumer price index had risen only 10.8 percent over its level in February 1968, the date of the last prior increase, so that there is some question as to the necessity for the 5 percent increase. We would further note that the combined cost of the 15 percent and the 5 percent increases, when added

to the cost of the other proposed benefit liberalizations, as well as increased Medicare costs, will exert serious pressure on the financing mechanism. Most certainly, the increase should not exceed 5 percent at this time.

AUTOMATIC ADJUSTMENTS FOR FUTURE CHANGES IN THE COST OF LIVING AND AVERAGE WAGE LEVELS

H.R. 17550 includes provisions for automatic adjustment of benefits and the taxable earnings base to reflect future changes in the cost of living and average wage levels. These provisions were not included in the bill reported by the House Committee on Ways and Means but were added on the House floor.

We do not favor automatic adjustment provisions. Social Security benefits and taxes are a very important part of the economy. Both the system and its financing have become increasingly complex as additional types of benefits have been added. We believe that the extent and timing of changes in either benefits or taxes are of such importance that prior review by Congress is necessary in order to tailor the changes to fit the economic situation prevailing at the time.

Additionally, inclusion of automatic adjustments in the Social Security System would be interpreted by many as an explicit acknowledgement of the inevitability of continued inflation. Any such belief on the part of the American public would be highly undesirable in that it would add to the dangerous psychology of inflation which already prevails in our economy.

We are confident that Congress will, as part of its periodic reviews of the Social Security system, continue to make necessary adjustments to reflect cost-of-living increases. These periodic reviews—and adjustments, if necessary—will help to keep the issue of inflation, and its effect on our older citizens, before Congress and the American public.

INCREASE IN EARNINGS BASE

H.R. 17550 would increase the earnings base—that is, the base on which the Social Security taxes as well as benefits are computed—from the present level of $7,800 to a level of $9,000, effective January 1, 1971. We believe this increase would be premature.

Let me be more specific:

We believe that the average earnings of regularly employed male workers represent an appropriate dividing line between the area in which the government should have responsibility to provide basic retirement benefits and the area in which the individual and his employer should have responsibility to provide retirement security through private media. In our opinion, the Social Security system clearly reaches beyond its role of providing basic economic protection when it provides benefits based on above-average earnings, as would be done under H.R. 17550. Likewise, when the system raises revenues through taxes at these above-average earnings levels, it drains off financial resources which the individual and his employer might otherwise put into private savings. In each situation, the freedom of individual choice is eroded.

Under our estimates, the average earnings of regularly employed male workers will not reach the $9,000 wage base contained in H.R. 17550 until 1974 or 1975. Thus, this increase to $9,000—to be effective on January 1, 1971—would bring the earnings base to a level substantially in excess of the estimated average earnings at that time. This increase would entitle workers with above-average earnings to additional Social Security benefits based on their earnings included in the newly covered wage band. Likewise, it would require younger workers at these earnings levels to pay additional Social Security taxes in an amount far in excess of the cost of the new benefits they will receive. In both these respects, the proposed earnings base increase would seriously impede the ability of—and undermine the incentive for—the affected individuals and their employers to provide for retirement income through the many types of private media available.

Moreover, using an increase in the earnings base as a mechanism for financing across-the-board benefit increases, or otherwise carrying out the provisions of H.R. 17550, is an inefficient process. This results from the fact that part of the additional revenue which is raised will be drained off into providing benefits on earnings above the level presently appropriate for Social Security. Thus, only a portion of the increased revenues will be available for meeting the cost of the benefit increases and other changes which are the primary objective of H.R. 17550.

These same problems would arise in any instance in which the taxable earnings base is increased above average wage levels as a means for financing benefits unrelated to the retirement needs of the workers who would pay the increased taxes. Thus, for example, if the wage base were to be increased to finance increases in the minimum benefits under the Social Security retirement program, the by-product would be an increase in Social Security benefits—and taxes—for workers with above-average earnings. This, in turn, would leave only a part of the revenues available for the intended purpose. Moreover, by imposing taxes and providing benefits on above-average earnings, the Social Security system would be pre-empting an area properly left to the private retirement system.

At this point, although the issue is not raised directly by H.R. 17550, I would like to make a few additional comments with respect to the minimum benefit aspect of Social Security in view of past efforts to raise these benefits significantly. Even aside from the question of the method of financing such benefits, we believe that it is undesirable to provide minimum benefits under the Social Security retirement program which significantly exceed the benefits otherwise payable under the present benefit computation formula. This conclusion is based on the view that Social Security was intended to be, and should remain, a wage-related system, and is an improper vehicle for attempting to cure the problems of poverty. More specifically—

(A) The fact that there is a relationship under the Social Security retirement program between the amount of wages (and thus taxes) paid with respect to an employee and the amount of his benefits provides a rational framework for determining the level of taxes and benefits. The inclusion of large minimum benefits under this program—which are far out of proportion to the wages on which payroll taxes were paid on behalf of the recipients—would seriously undermine this highly desirable aspect of the Social Security system.

(B) A flat increase in the minimum benefit would accrue to the benefit of many people who are clearly not in a poverty status. These include individuals who have worked only a minimum period under Social Security, but have spent a large part of their working career with the federal government or a state or local government or else in some other business or profession that was not always covered by Social Security, but which provides its own retirement system. Thus, an increase in the minimum benefit represents a very expensive and inefficient means for trying to alleviate poverty in the elderly age group. Moreover, we do not think it would be possible to structure a minimum benefit formula within the framework of the Social Security retirement system that would not have this aspect of inefficiency in it.

(C) Finally, we think the problems of the elderly poor should be considered, and resolved, as part of an overall revision of the wefare system as it applies to all age groups within our society and not solely in the context of revisions to the Social Security retirement provisions.

To return to the issues raised by H.R. 17550, we believe that until the level of average earnings justifies an increase in the earnings base, increases in Social Security benefits should be financed through any favorable actuarial balance in the present program, and beyond that the Social Security tax schedule should be drawn upon as a source of funds. Adherence to these principles will insure that the Social Security system remains in a self-supporting posture while at the same time financing its benefit increases in an efficient manner and in a manner that is consistent with its role in relation to private retirement media. These, we think, are extremely important objectives which should be followed by the Social Security system.

LIBERALIZATION OF THE RETIREMENT TEST

We support the provisions in H.R. 17550 for increasing the amount an individual may earn without a reduction in Social Security benefits and for revising the formula for reducing Social Security benefits when earnings exceed the exemption level. We believe that these changes are not inconsistent with a sound retirement test. On the other hand, we oppose any provision for automatically raising the exemption level to reflect future increases in wage levels. We take this position for basically the same reasons we oppose automatic adjustments in the benefit levels and the earnings base.

We understand that the American Insurance Association, the American Mutual Insurance Alliance and possibly others will present testimony in opposition to that provision of H.R. 17550 which would increase the ceiling on combined disability and Workmen's Compensation benefits from 80 percent to 100 percent of average current earnings prior to disability. We concur in their position that this increase would have an adverse effect on the incentive for rehabilitation as well as on the Workmen's Compensation program in general.

I appreciate this opportunity to present the views of our three associations. If the Committee members have any questions, I shall be happy to try to answer them.

The CHAIRMAN. Thank you very much, sir.

The next witness, then, will be Mrs. Elizabeth Boggs, if she is now here.

STATEMENT OF ELIZABETH M. BOGGS, CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR RETARDED CHILDREN

Mrs. BOGGS. Thank you, Mr. Chairman.

My name is Elizabeth Boggs, and I am representing the National Association for Retarded Children.

You have our statement, I think, before you, and there is a one-page summary attached.

It is not my custom to speak in personal terms when testifying before such august bodies, but in this instance I would like to introduce my remarks with a couple of personal references.

At this time last year, my 90-year-old father was hospitalized with a fatal cancer. He was a man who, when the Social Security Act was introduced, opposed it. He had a strong sense of individual responsibility, rugged individualism, and he was opposed to the general principles.

Nevertheless, he was in covered employment, and when it came to the last years of his life, and he was faced with this very difficult period of months of pain and suffering, it was possible to alleviate his physical pain somewhat, and it was possible to relieve his mental anguish considerably, when I said to him:

> Father, the medicare program will pay most of these hospital expenses that you are incurring.

He was visibly relieved, and it was possible for him to die with peace of mind knowing that my mother's lifetime savings would not be wiped out by his last illness.

The program of medicare, together with the supplementary Blue Cross and Blue Shield, which they carried, paid out something between $9,000 and $10,000 on his account.

We, as a family, are very grateful for this. I may say I learned a few things about why the program is costly to administer. I figure that the medicare and Blue Cross and the hospital and I spent about $50 of our time and effort settling a $24 laboratory claim, but this is not the point of my argument.

The argument is that something important was done through the insurance principle to mitigate the catastrophic impact of this disease.

But there is another side of this story. I have a son, now 25, who is profoundly mentally retarded, cerebral palsied and an epileptic, due

to an illness that occurred shortly after his birth. The costs, direct costs, of that illness were inconsequential as we look back, probably less than $1,000. But we, my husband and I, who are not wealthy, my husband is a university faculty member, have paid over the past 20 years over $50,000 in the costs of care in public and private institutions, for this child, who is not able to meet his own expenses, and none for this care is insurable under any private insurance plan in the country nor under any so-called social insurance plan which you have put forward to date.

The contrast between these two situations, I think, indicates to you why we, in the Association for Retarded Children, feel that in all the rhetoric about national health insurance and the rest, we should consider the truly catastrophic consequences of illness as part of the subject to be insured.

It is less important to cover a tonsillectomy than it is to cover these on-going severe costs that are incurred by relatively few people but which bear very heavily upon those few.

We come to you particularly at this time in relation to the problems created which straddle H.R. 17550 and H.R. 16311, in particular reference to section 1121, intermediate care.

As you are well aware, there are provisions for amending this particular section in both bills. The provisions are not consistent with one another. In respect, particularly, to the institutional exclusions, I want to say that, so far as we are concerned, both the proposed amendments, the amendments to both of the bills, are unacceptable and regressive and work against the best interests of people with long-term disabilities, particularly those originating in childhood such as I have described.

They work against these people because the majority of the resources that are available to these people at the present time are public, and by making it possible to pay when the facility is private but not public, on the one hand, and pay when it is nursing care but not when it is "non-medical" care, on the other hand, produces invidious distinctions which simply create incentives to the States to do the wron gthing, or disincentives to do the right thing by the patient and by the taxpayer.

We believe that the concept that you all developed when you proposed the intermediate care idea was a very sound one. I reread that language and I think it is masterful language.

The problem is that people are attempting now to limit it by various kinds of interpretations and by saying what the legislative history was—although I cannot find the legislative history that tells us—that gives the justification for narrowing your definition.

They seem to be saying that if the States does something that is more expensive because it is medical we will allow it. If they do something which is truly constructive and it is called social rehabilitation or it is delivered by somebody other than nurses but trained to do the job, you won't allow it.

I respectfully submit to you that the concept should be seriously considered which is given in our table, near the back of the testimony, it is just before page 10, in which we outline the continuums of institutional care, and indicate that hospitals, skilled nursing home care, and the so-called medical model of ICF might be considered one line

of relationships, and that contiguous with that there should be another line of relationships which also deal with the ICF, but one which is not necessarily staffed with nurses but is staffed to give additional service over and above board and lodging and custodial care, as you intended when you drafted that legislation. Anyway, we think that is what you intended.

We believe that several different kinds of intermediate care should be recognized, and if this is done you will maximize the advantages to the patient, you will make best use of the professional manpower which is available; you will create a system which, if appropriate standards are also mandated—the word "appropriate" is operational here—will produce value for the money spent; that, I think, has been the critical issue in all these hearings, as I have been listening to them.

When money is wasted, it is misspent, and you regret it and we regret it, and, above all, the beneficiaries regret it. If it is spent to good advantage I do not think you begrudge it, and I do not think the taxpayers begrudge it.

Thank you, sir.

(The prepared statement of Mrs. Boggs follows:)

STATEMENT IN BEHALF OF THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

SUMMARY

We recommend—

1. Extension of Medicare at least to adult child beneficiaries under social security;

2. The elimination of any and all discrimination against persons in public institutions for the retarded as against comparable persons in comparable private institutions, in respect to entitlements under Title XIX or Section 1121 (Intermediate care);

3. Addition of explicit authority for the Secretary to establish (directly or by reference to a national accrediting body) standards for various types of intermediate care facilities appropriate to persons described in Section 1121(b) including the retarded;

4. Clarification as to the range of types of care which can be included under "intermediate care" so as to cover both "medical" and nonmedical models and staffing patterns and also "partial" institutionalization along with 24 hour care;

5. Modification of the Bennett amendment to promote participation of other professionals (in addition to physicians) in the review of care given by "peers" as, for example, in facilities for the retarded.

6. A requirement (for receipt of title XIX or Section 1121 reimbursement) that each State identify its expenditures for health care and social care of the retarded according to state agency responsible and according to general program categories provided in its State Plan for the retarded, and show that it is ploughing back its Federal augmentation so as to increase the total quality and quantity of service to this group of citizens (specific maintenance of effort).

7. A recognition by this Committee of the need to regard social services as part of a single continuum and the need to remove "notches" between them by establishing consistent standards of eligibility, levels of federal reimbursement, open-endness and incentives that reward constructive and responsible behavior toward the clients as well as the taxpayers.

The National Association for Retarded Children is the voluntary citizen organization working on behalf of retarded children and adults in all states, and territories. The work of your Committee has brought tremendous advances to the nation's 6 million retarded citizens in the 20 years since NARC was founded. We salute you and urge you to continue in this tradition.

PRINCIPLES

Our position in respect to HR. 17550 is based on the application of a few basic principles:

1. The mentally retarded are people, citizens, with a handicap or disability; as such they are entitled to the same protections, services and recognition as other citizens who have special needs.

2. Each individual disabled by mental retardation is, like other disabled or impaired individuals, entitled to the type of specialized care, (whether residental or non-residential, whether medical, or social-rehabilitative, or "remedial" or educational, or developmental, or supportive, or "personal") which is most appropriate to his particular needs and condition.

3. Federal intervention in the health-rehabilitation-social services and care system complex should reinforce the foregoing "most appropriate care" principle by (a) participating in its cost on behalf of needy individuals and (b) fostering the sponsorship and development of facilities and resources by competent agencies *both public and private;* such resources should include a diversity of types as well as "levels" of care.

We find much in HR. 17550 and the present SSA which is inconsistent with these principles.

PRACTICE

The legislation before you affects mentally retarded children and adults in many ways, some good, some bad and some uncertain. Our experience in the past five years has made us expecially skeptical of uncertain and ambiguous provisions. They are generally resolved to the disadvantage of the unwitting clientele whose interests are the concern of our Association.

WHAT IS GOOD

1. The proposed increases in social security benefits including the cost-of-living tie-in.

2. The more consistent schedule of disregards of earned income for beneficiaries.

These two proposals affect directly approximately 160 thousand retarded adults disabled in childhood who are beneficiaries under Title II of the Act.

WHAT IS BAD

1. *The continued omission of provisions to extend Medicare to the disabled.*

A succession of informed advisors, individuals and groups, have recommended this extension beginning in 1965.

Since there has been reluctance to entitle the entire disabled beneficiary group, we urge that the disabled adult child beneficiaries be phased in *first* and soon. This group is smaller than the disabled workers and there is some actuarial experience developing in those states where disabled children are continued in coverage in private group health plans past age 19 when they are dependent on an insured parent. When this parent dies or retires the group coverage ceases. At the same time the disabled adult child will likely qualify for social security benefits. He therefore needs health insurance to complement these benefits. Extension of medicare would give him coverage for his acute or inter current medical care although it would not cover long term care. We believe that adults disabled in childhood will, as a group, prove to have somewhat lower health costs (on medicare covered items) than disabled workers, since the cause of their disability tends to stabilize before they become eligible. Therefore the risks they run are much like those of other adults.

2. *The continued exclusion of "inmates" of public institutions (other than medical institutions) from any benefits under Title XIX. (See section 1905(a)(15)(A)).*

It should be noted that this means that the person who is a resident of a public institution (but not as an "in-patient") is denied physicians services, physical therapy, out-patient clinic services, "home health" care etc., etc. if the "home" or "facility" in which he chooses or is forced to reside is publicly sponsored. Since budgets to provide intermittent medical care for persons in such facilities are usually both closed ended and limited, this means that these persons, indigent as they are, are denied the *right* to quality medical care which Title XIX is supposed to bring. The only way in which such a person can receive medical

care under medicaid is by being transferred from the public institution to a hospital or nursing home and becoming an in-patient therein. This exclusion, we maintain, is arbitrary and unreasonable and contrary to the administration's alleged intent to provide incentives for improved utilization along with optimum care.

3. *The exclusion under Section 225 of H.R. 17550 of any "public institution for mental diseases or mental defects" from recognition as an intermediate care facility under Section 1121 of the Act.* (We find equally invidious the language of H.R. 16311 Section 402(10)(B) excluding "a public institution other than a medical institution" from qualification as an intermediate care facility.)

We believe that the language of Section 1121(b)(1) should be allowed to override any institutional exclusion in Titles I, X, XIV and XVI.

We recommend that you abandon both these proposed amendments, and, for clarification, insert the words "a public or private institution" in lieu of the words "an institution" the first time they occur in Section 1121(e).

Briefly the exclusion of public facilities which offer care equivalent and sometimes even superior to that offered in an available private facility represents an injustice to a disabled person, limiting on his freedom of choice (since state practice may force him to go to a private facility where he minimizes state cost by maximizing federal aid) and a deterrent to appropriate resource development. This is especially true in a field such as care of the mentally retarded where at least 90% of the available space for specialized care of adults has been developed under public auspices. This is not the time to discourage public initiative in developing resources as a complement to private entry.

It should be pointed out that the proposed exclusions are likely to force over-rapid expansion of proprietary facilities which in turn will make difficult the proper control and maintenance of standards by state agencies; moreover, with respect to the aged and disabled and particularly the mentally handicapped, any expansion of private residential care should be accompanied and even preceded by the development of a state system of protective services to prevent exploitation of the helpless and incompetent. Few states have planned such systems or counted the cost of doing so.

In the staff report of February 9, 1970 (p. 100) it is stated that "Congress may at some future date afford Federal matching funds for care of mentally retarded persons in public institutions. . . ." May we respectfully urge that the time has now arrived. Coupled with appropriate standards and controls, including independent program audits, such action on your part would be a fitting and timely complement to the Long amendment of 1965 which did so much for the aged mentally ill. Your explicit recognition of the multifaceted needs of the mentally retarded would help to accelerate the break away from the old custodial models.

4. *The failure to give clear authority to the Secretary to establish, either directly or through reference to accreditation by recognized national bodies, standards for various general and special classes of intermediate care facilities* (both "medical" and "nonmedical"—see below).

We believe basic national standards are necessary and desirable: we understand that the lack of express authority to establish standards of care beyond mere sanitation and safety has tied the hands of the Secretary and caused the "watering down" of standards originally announced in 1968.

We wish to point out that our Association has played an active role in bringing into being a national Council on Accreditation of Facilities for the Mentally Retarded which will operate as one of several "categorical councils" under the umbrella of the Joint Commission on Accreditation of Hospitals. This new accreditation council is composed of representatives of professional and consumer organizations with competence in this special field. It is developing standards and accreditation procedures which will cover a wide range of facilities, both medical and non-medical.

NOW FOR THE AMBIGUITIES

Intermediate care

Is an intermediate care facility a "medical institution", a "health care facility" or something else? Senator Bennett's amendment refers to "a health care facility (including any facility for intermediate care)". However HR. 17550 appears to equate "health program" to titles XVIII, XIX and V, excluding Title XI. In the staff report of February 9, 1970 it is argued (p. 100) that if a facility is a "medical facility," section 121(b) of the Act precludes payment except through Title XIX; this implies that an intermediate care facility can

not be considered "medical". Yet the definition refers to "patients or residents", implying that both medical and non-medical facilities are includable. The Task Force on Medicaid and Related Programs (Section II G) recommends as follows:

The Department of Health, Education and Welfare should consider—that the Intermediate Care Facility remain generally defined as a zone of personal and residential service between the Skilled Nursing Home and the domiciliary institution to allow flexibility to the States for further definitions.

That the regulation on Intermediate Care Facilities be strengthened to require activity programming to provide a creative and constructive environment in these institutions.

That in relation to the Medicare program the Intermediate Care Facility be considered a long-term care and not a medical-care institution; particularly that a stay in an Intermediate Care Facility should be considered to break a "spell of illness" and after a stay for a sufficient period of time, the person is again eligible for hospital insurance benefits.

We believe that this Committee did an excellent job in drafting its original 1967 definition of intermediate care facility. (Section 1121(e)) To us it describes well the wide variety of social-rehabilitation or health-supervision settings which are appropriate to certain retarded persons who are disabled but who are not among those who require skilled nursing care.

We urge you to clarify, once and for all, the breadth of this definition and the opportunity it offers for the development and utilization of a variety of general and special types of facility appropriate to the needs of persons of various ages and kinds of impairment.

Such facilities should be seen as several parts of a continuum of out-of-home care as diagrammed herewith. It should include both medically oriented facilities and facilities staffed primarily to provide social rehabilitation and/or supportive services which are not under continuous medical supervision. No "notches" should occur between types of facilities which are at the same level but are of different types. Thus a "social rehabilitation" facility could be justified in charging comparable fees to those allowed to a skilled nursing home when the facility has comparable staff ratios but employs non-nursing personnel qualified to enhance self-help skills and direct appropriate activities for mentally disabled persons.

We would also urge that, just as the "partial hospitalization" concept has been accepted, so also should the "partial ICF" be accepted as a facility offering social supervision during leisure hours and at night to a person who is nevertheless able to leave the facility for a certain part of the day on a trial work assignment or to utilize another facility offering appropriate daytime activities or social services. Again, such appropriate "alternative" programming should be recognized as an ICF, for Federal participation (regardless of its sponsorship) both in justice to the disabled or aged persons who used it, and to encourage optimum utilization of appropriate facilities and personnel.

APPLICATION OF TITLE XIX—MAINTENANCE OF EFFORT

For fiscal 1969, eleven states claimed Medicaid funds for mentally retarded patients who were considered to need hospital or skilled nursing care which was made available in units within public institutions for the retarded. While some of the claims of some of these states have been questioned and while (to our regret) some of the funds simply replaced state money and thus eased the general medicaid burden to the states, there appears to be no doubt that under proper controls and standards, such medical care in such institutions for eligible patients who need such care is a justifiable claim under Title XIX. As already indicated we believe that intermediate care of both "medical" and non-medical types, should also be recognized. However, we also believe any state receiving funds either under Title XIX or Section 1121 should identify its expenditures for the mentally retarded and demonstrate that the federal participation has brought about an equivalent increase in total state expenditures for services to the retarded, including demonstrable improvement in the standards of care in public institutions. We recognize that "maintenance of effort" clauses are hard to enforce. However, an expression of your intent could be a powerful persuader of legislatures and state budget offices who have already doubled their per capita expenditures for public residential care of the retarded since 1963. (See attachment.)

TABLE I.—CONTINUUM OF INSTITUTIONAL CARE

Level and type	Intensive	Live-in plus in-services: Extended	Live-in plus in-services: Supportive	Live-in plus out-services
Medical	Hospital	Skilled nursing home.	ICF medical (practical nursing).	
Social-rehabilitation	Intensive rehabilitation facility (vocational-social)	ICF extended social-rehabilitation	ICF social-protective.	ICF partial institution (hostel, group home).

TABLE II.—RECENT TRENDS OF PATIENT MOVEMENT AND ADMINISTRATIVE DATA, PUBLIC INSTITUTIONS FOR THE MENTALLY RETARDED, UNITED STATES, 1963 AND 1969

Item	1963	1969
All admissions	14,909	14,868
Net releases	8,156	14,701
Deaths in institutions	3,498	3,621
Resident patients end of year	176,516	189,394
Personnel (full time) at end of year	69,494	107,737
Maintenance expenditures	$353,574,933	$764,605,791
Per resident patient:		
Per year	$1,984	$3,995.58
Per day	$5.44	$10.95
Per patient under treatment:		
Per year	$1,879.43	$3,681
Per day	$5.15	$10.08
	Index numbers	
All admissions	100.0	99.7
Net releases	100.0	180.2
Deaths in institutions	100.0	103.5
Resident patients end of year	100.0	107.3
Personnel (full time) at end of year	100.0	155.0
Maintenance expenditures	100.0	216.2
Per resident patient:		
Per year	100.0	201.4
Per day	100.0	201.3
Per patient under treatment:		
Per year	100.0	195.9
Per day	100.0	195.7

From: Mental Health Statistics—Current Facility Reports provisional patient movement and administrative data—July 1967-June 30, 1968, Division of Mental Retardation, RSA, DHEW.

CONCLUSION

The states and communities have come a long way in care and rehabilitation of the retarded, but there is a long way yet to go. Until recently there has been relatively little direct federal contribution to improving and extending services to this group of citizens despite the special problems confronting them and their families, and despite the catastrophic character of the prolonged disability from which many of them suffer. May we urge the Committee to consider the needs of the retarded for a full range of health-education-social-rehabilitation and employment services, and the appropriate role of various titles of the Social Security Act in meeting the health, welfare, and social services components within this still broader range.

Thank you.

The CHAIRMAN. Thank you very much.

Any questions?

You made a very fine statement, Mrs. Boggs, and I will see to it that this matter is considered when we go into executive session.

That concludes the witnesses for today. The committee stands in recess until 10 o'clock tomorrow.

(Whereupon, at 3:55 p.m., the committee adjourned, to reconvene at 10 a.m., on Tuesday, September 22, 1970.)

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